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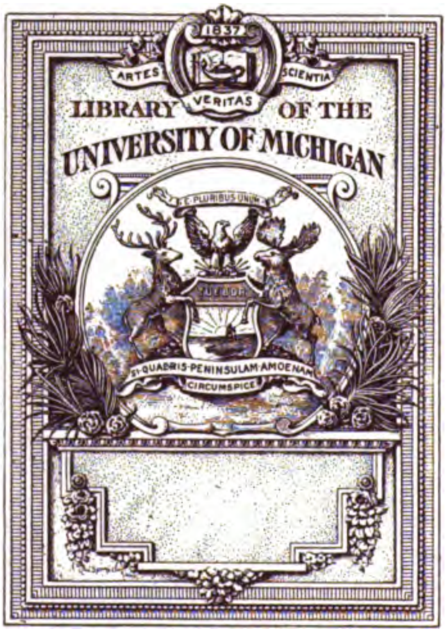
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MEDICAL TIMES.

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FRACTURE OF PATELLA TREATED BY SUTURE.

By C. N. ELLINWOOD, M. D., Acting Professor of Clinical Surgery, Cooper Medical College, San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

Surgical literature is crowded with observations and discussions of fracture of the patella. Ten pages are given in the Index Catalogue of the Library of the Surgeon-General's office, at Washington, to the titles to papers on this subject, already placed in that library, and yet this does not embrace all the valuable contributions which have been made to this practical question. It continues to be a fertile field for study and new methods of treatment, which indicates that there remains a diversity of opinion and unsatisfactory results.

I have sought in vain for some standard of synostosis, after a transverse fracture of the patella, which could be incontestibly called good and satisfactory. A fibrous union is all that is usually expected; and the fibrous band may be long or short, and yet good use of the limb be obtained, for a time.

By some surgeons it is argued that separation of the fragments of an inch or more is advantageous in preventing refracture, and even a separation of four inches, with a firm fibrous band of union, has given a limb which functioned well and a so-called satisfactory result—satisfactory to the surgeon who treated it.

Bryant says: "To allow the patient to flex the limb under three months, is a hazardous proceeding, for the uniting ligament is sure to be stretched and elongated and the limb weakened. A good leather knee cap should be worn permanently after this accident," and he concludes "that even with a great separation of fragments a very useful limb is, as a rule, secured."

This is no doubt true; but when we consider how frequently it happens that such a repaired patella is refractured, when the bearer of it relaxes his caution; forgets he has a weakened limb, and puts it to ordinary use, then the uniting band of fibrous union gives way. Or, what more frequently happens, the altered relations of the remaining sesamoid bone itself is allowed to bear forcibly upon the lower extremity of the femur, in strong flexion of the leg, and you have a separation of the bone at another point, by a cross breaking strain.

fracture of the patella. The results have been so successful and so much better than the ordinary fibrous union obtained by approved methods that it is now used in some European hospitals in all primary cases of this fracture.

The results reported from these sources are so favorable and comparatively superior to those obtained in the usual practice, in getting a firmer union and a more perfect limb, that it becomes a question whether this method should not be generally adopted. The procedure is simple, easy of accomplishment, and the time required for recovery is greatly diminished.

The argument against it, and probably the only one, is the danger of infection; but is not this overcome by a perfect asepsis?

From the many cases of suture of patellar fractures, I would mention the following report of two cases of ununited fracture of the patella[1] by Professor Lister.

Case I.—Eight weeks after the fracture, the fragments were more than an inch apart. There was fluctuation between the fragments, evidently fluid in the joint; fragments could not be brought into apposition. November 12, 1880, exposed the fragments by incision and sawed off the edges of both fragments; drilled them and passed a thick silver wire through the holes, and then, by complete flexion of the thigh on the abdomen, and strong traction on the wires, the fragments were brought into apposition and secured by twisting of the wires. Primary union followed. On January 28th, the patient could bend her knee a little, and was allowed to go out, and four weeks later an incision was made and the wire removed, resulting in perfect apposition, bony union and but little remaining stiffness.

Case II.—September 27, 1880, seven weeks after a transverse fracture of the patella, the fragments were separated ¾ of an inch with a fibrous band uniting the fragments. Knee joint stiff; no power of extension, but he could swing the leg forward in walking. October 22d, Lister made an incision 2 inches long and scraped the fibrous tissue from the two osseous surfaces; made an opening for drainage, through the capsule at the posterior aspect of the joint, and passed a tube; drilled the two fragments and passed a strong silver wire; brought them into apposition and held them by twisting the wire. November 20th, attempts at passive motion having been unsuccessful, chloroform was given and the joint flexed. This was followed by a cracking sound, indicating that something had given way; the wire had broken and air had entered the joint. November 26th: Operation of repeating the wiring of the fragments. February 5th: Walked fairly. Three weeks later the wire suture was removed, and in two months he walked well with a stick. There was no separation of the fragments.

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[1] British Medical Journal, June 11, 1881.

An annoying and serious sequel to the use of metalic wire sutures for the repair of fracture of the patella is reported by Mr. G. N. Turner, Surgeon to the Seaman's Hospital, Greenwich, March 10, 1887. The case was operated on by Mayo Robson, of Leeds, in 1885, who found difficulty in approximating the fragments, and divided the quadriceps muscle and wired the patellar fragments with three sutures of gold wire, which were allowed to remain, and a good recovery followed. A subsequent accident revealed the end of broken wire. A severe inflammation of the joint followed, which necessitated an incision, opening the joint, and removal of the offending wire. Recovery from this, with a useful limb. About two years after the first operation, the patient again fell on his knee, with a similar result of severe inflammation and suppuration. Incisions for drainage revealed other pieces of the gold wire, which, Mr. Turner remarks, "were troublesome to remove, and were not finally got rid of for some considerable time," but a strong osseous union had been accomplished by their use.

Malgaigne mentions a case of rupture of a fibrous band, attended by an enormous ecchymosis. Gangrene ensued on the fifth day, with a fatal result.

Mr. John Croft, Surgeon to St. Thomas' Hospital, reports in July, 1891, two cases of primary suture of the patella. In one case the operation was performed the day following the accident, and in the other case five days after the fracture. In both cases a large quantity of fluid and coagulated blood was cleared away from the torn surfaces and from the cavity of the joint. In each case the fracture surface of upper fragment of patella was thickly furred over with coagulum. In the fifth-day case there was a thick, firm layer of laminating clot on the fracture surface, which could be removed only by scraping. The lower fragment was at first invisible, and only came into view when the soft parts which had fallen in over its raw surface had been lifted out. A thick tongue-shaped piece of aponeurosis of the external quadriceps, which had been torn from the surface of the upper fragment, had become so wedged into the intercondyloid space that it quite masked the lower fragment. This served as a complete and material obstacle to the close approximation of the fragments, and of course to their bony union. When, in each case, this mass of aponeurosis and fibrous tissue was held aside, the cavity of the joint was cleared and the silver wire sutures inserted. The wound was sutured with fine silk; drainage established; antiseptic dressings applied, and the knee immobilized by a back splint. Primary union followed in both cases, and firm bony union in about a month's time.

M. Lucas Championnière, reported in July, 1891, to the Société de Chirurgie of Paris, 35 cases of primary suture of the patella, with the uniform result of bony union in from 20 to 30 days, and perfect limbs. No mention is made of infection, nor other accident in any of his cases.

In conclusion, I beg to report a case of transverse fracture of the patella treated by catgut suture, and to exhibit it to the Society:

James R——, a laborer, aged 40, March 14, 1893, sustained a transverse fracture of the left patella just above the middle line, and also a longitudinal fracture of the upper fragment, together with a superficial laceration of the skin in front of the patella. No surgical treatment was obtained. Rest was observed for two weeks when he began to hobble about, the leg frequently giving way in his efforts to walk and causing him to fall. April 28th, six weeks after the accident, there was found a separation of 1¼ inches on flexing the leg, and ⅝ of an inch with the leg extended. Prepatellar adhesions of the integument with its surface abraded; atrophy of thigh muscles; four centimeters less on the affected side. May 3d. the abraded surface of skin over the patella having healed, and the patient being thoroughly convinced of the uselessness of the limb without operation, an anesthetic was given, and the Esmarch bandage applied to the thigh. A transverse incision was made across the patella from the inner to the outer condyle of the femur, thus freely exposing the fracture surfaces and the joint, with a continued irrigation of sublimate solution 1:4,000. Both fractured surfaces of the sesamoid bone were covered by a firm fibrous tissue which I cut away until, apparently, viable bone tissue was reached. This caused a considerable shortening of the upper fragment, and showed its longitudinal fracture distinctly. The osseous tissue was quite softened, and I continued to scrape and cut away from its surface until a little blood oozed from it, when two holes were drilled through the larger and lower fragment and corresponding holes above, one passing above the bone, on account of its fragile condition, through its quadriceps attachment. Large catgut sutures were introduced, one of them doubled, and a fair, though not exact, coaptation thus obtained. The joint was thoroughly irrigated with a 1:2,000 sublimate solution to make sure of leaving no debris from the operation; the sutures were securely tied and the wound closed by silk sutures, leaving a short drainage in either extremity of the incision; an antiseptic dressing was applied, and the knee immobilized by a posterior splint.

The temperature rose the following day to 100.8°, but the next day was recorded as normal, and so remained during the entire convalescence. May 20th, the first dressings were removed, slightly blood stained; no odor; no pus; external wound united, and good apposition of the fragments maintained. Redressed. May 25th, an examination showed firm union of the fractured bone, which was carefully held and passive motion commenced, and repeated daily. June 2d, patient discharged, with a firm bony union, walking well, and increasing power of flexion.

715 Clay street.

CLINICAL OBSERVATIONS AT SOME EASTERN HOSPITALS.

By Andrew C. Smith, M.D., Portland, Or., Member of Staff, St. Vincent's Hospital; Surgeon to Multnomah County Hospital; Lecturer on Clinical Surgery, Medical Department University of Oregon.

Read before the Portland Medical Society.

In compliance with a suggestion that I should read a paper this evening, relating to observations on my recent trip, I will endeavor to present for your consideration some points that impress me as being of special interest in surgical matters.

I had expected to be surprised by many entirely new procedures. While there are a few, I found that although the Pacific coast was very far west, it was not very far behind in the procession of medical and surgical advance.

I was early impressed with the fact that the sumptuous elegance and elaborate appointments of many of the modern hospitals, together with the halo of professional glory that usually surrounds their staffs, have done much to overcome the prejudice of the paying classes against hospitals, and that they, together with the greatly abused public clinics, are working a great hardship on the rank and file of the profession.

If I were asked to name the most prevalent fad of the day among surgeons, I would say that it is an effort to operate more rapidly than one's neighbor. While I recognize that rapidity is desirable, I believe that this is often accomplished at the sacrifice of that minute attention to detail on which success largely depends. I saw the peritoneal cavity opened in two strokes of the knife, and a double oöphorectomy completed in 17 minutes. I did not regard this "exhibition" as a conscientious endeavor for the patient's welfare.

Among the many subjects on which I found a wide difference of opinion as to *technique*, I will first mention intestinal anastomosis.

That our science is not yet absolute or in any degree axiomatic, is frequently manifested by these great diversities of method on important subjects. While Senn's great reputation and influence are still in favor of the plates which bear his name, we find such shining lights as McBurney, Bull, Abbé, and Halsted, completely ignoring them, and recommending only "free-hand" anastomosis. It is probable that in the hands of such experts this method would suffice; but as a procedure for general adoption, it is too slow and difficult, and will, no doubt, give way to the use of some mechanical time-saving contrivance.

The most ingenious, expeditious, and effectual instrument thus far introduced, is the "anastomosis button" of Dr. J. B. Murphy, of Chicago. It can be easily and quickly placed, and insures sufficient lumen, while pressure necrosis and peritoneal adhesion are rapidly produced, and the button is safely discharged in a couple of days, leaving a complete, permanent, and ample anastomosis. For end-to-end anastomosis, I can not imagine a more perfect appliance, as it may be used as large as the calibre of the bowel will admit, thus tending to prevent the subsequent narrowing of the part. It is said by some who have never used these buttons, that they do not insure a sufficiently large aperture for lateral anastomosis; but this is only a theoretical objection, as they may be modified to insure an anastomotic aperture of any desired calibre. Murphy has completed an anastomosis by their use in 4½ minutes, and any ordinary operator can place them quickly and safely.

Another class of work which it is hoped will soon show a definite and generally accepted procedure, is the operation for radical cure of hernia. We have, during the last few years, been presented with a continuous succession of methods for the relief of this very prevalent defect, and still the march goes on, without any particular procedure being generally adopted.

The old Banks operation, with its many modifications, gave way largely to Macewan's, which has given brilliant results. I should be loth to abandon it, since I have not had a single recurrence where I have followed its cardinal points. McBurney's operation is not standing the test of time, and is rapidly being abandoned. Kocher's operation, of twisting the sac and bringing it through the external aponeurosis, opposite the internal ring, and then subcutaneously over the inguinal canal, seems far-fetched, and is not being generally adopted in the United States.

The operation which, if any, should supercede Macewan's, is Bassini's, or Halsted's modification of it. Bassini's operation is just now very popular, but whether it has come to stay is a question. It consists in opening up the inguinal canal, cutting off the sac, lifting the cord out of its bed, and then closing the entire canal, including the external ring. The external aponeurosis is not included in the approximation of the margins of the canal, but is closed by continuous suture over the cord, thus making for it a new canal, and entirely obliterating the inguinal tract. Halsted's improvement on this operation consists in using his "mattress sutures" of silk, which insure more lasting coaptation, and including the external aponeurosis, thus leaving the cord entirely external, or subcutaneous only. The material now generally preferred for buried sutures is kangaroo tendon.

Appendicitis, although worn nearly thread-bare during the past two years, is still a prominent topic. It is evident that the safest men regard early operation as true conservatism in this ever treacherous and oft recurring affection. When, however, it has resulted in suppuration, from which the general peritoneal cavity has been protected by inflammatory exudate, there should be no search made for the appendix, lest the required manipulations result in general peritoneal infection. Cautious incision into, and gauze drainage of the abscess cavity, would, under these conditions, be sufficient.

The occasional insidious approach of these appendix inflammations was well exemplified in a case upon which I operated at St. Vincent's Hospital a few days ago. The patient, æt. 58, came to my office, complaining of unusual tenderness in a large, right scrotal hernia. He had had slight rigors, and the temperature was over 100° F. He could not tolerate his truss, nor could he bear any attempt at taxis. I suspected a partial strangulation, and advised him to go at once to the Hospital, and submit to operation. His symptoms soon improved while in bed, and the rupture became easily reduceable, but the temperature varied from normal to 100°. I advised Bassini's operation, for exploratory as well as for radical-cure purposes. This was done ten days ago, in the presence of the class. One of the contents of the sac was the cecum, with its vermiform attachment in a state of great distension, from muco-purulent fluid, and containing a fecal concretion. This explained the pyrexia and tenderness. After removing the appendix, the cecum was reduced with the other contents of the sac, and the operation completed as an ordinary Bassini radical cure, without drainage. All the symptoms have disappeared, and the patient, though alcoholic and more senile than his years justify, is doing well.

Another subject on which we find much discussion is the exact *technique* of perineal repair. The general verdict seems to be that Tait's flap-splitting hobby is unsurgical, and is destined soon to be consigned to oblivion. Many names are being given to perineo-plastic procedures, but they are mostly the result of a strained effort at originality on the part of operators who are anxious to attach their names to something. They are generally but slight modifications, and, often unwarrantable, departures from the principles enunciated by the great master in this line of work—Thomas Addis Emmett.

The exact manner in which abdominal hysterectomy should be performed is worth considering, since it, too, is still in a stage of evolution. The question as to whether the stump should be extra, or intra-peritoneally treated, has, I think, been finally decided in favor of the latter. There are still a few who adhere to the external method, but they are not the leaders, or the men who do the bulk of this work. As to the particular method of intra-peritoneal treatment, I believe that the operation known as Baer's is the best. It is the ordinary supra-vaginal amputation, with the stump closed over by peritoneal flaps, the hemorrhage being controlled by ligation of the uterine arteries in the broad ligaments, before amputating. In all malignant cases it is better to do complete hysterectomy. Polk and others are advocating entire extirpation in all cases which require removal of the appendages. While I believe this to be ordinarily too heroic a measure, it would probably be a valuable alternative in pyo-salpynx cases of extreme difficulty, owing to extensive and dense adhesions.

As bearing upon this subject, I will relate the details of an operation which I witnessed at Johns-Hopkins Hospital. It is of particular interest because of the fertility of resources and general surgical skill displayed during the operation. The case was one of extensive malignant disease of the uterus, which Dr. Howard A. Kelly was about to remove *per vaginam*. He soon found, however, that owing to the density of fixation, that operation was impracticable. He then quickly determined upon abdominal section. Matters progressed favorably for a while, when the numerous friable adhesions began bleeding alarmingly. It was too late for retreat. Did he abandon the woman to her fate? No. He quickly concluded that nothing short of ligation of both internal iliac arteries would control the bleeding and permit of further progress. This was done in short order, and the operation proceeded with. It was not long till uterus, broad ligaments, and other infiltrated tissues were removed, but before this was quite accomplished, the anesthetist announced that the patient was profoundly shocked, and would not survive the operation. Dr. Kelly ordered an assistant to transfuse normal saline solution. This was done, directly, into the radial artery, toward the heart, while he went on with his herculean task. When the operation seemed completed, it was discovered that the left ureter was imbedded in a mass of infiltrate which could not be attacked without endangering that important structure. Again were minute anatomical knowledge and great surgical skill brought to bear; the ureter was isolated at a point above its malignant environment, through which it was carefully followed and extricated. Removing the mass completely he dropped the ureter back into a comparatively healthy bed, and proceeded to close up the abdominal cavity. The pulse, which before transfusion could not be counted, had now dropped to 120, and the respirations were easy and regular.

As I considered that in the event of recovery this would be the greatest surgical triumph I had ever seen, I asked Dr. Kelly if he would inform me of the further progress of the case. The doctor subsequently wrote me, under date of November 2d, as follows: "You will be pleased to hear that our patient whom we transfused, etc., has made an excellent recovery, and is up and about."

While speaking of Dr. Kelly, I am reminded of a new line of work that promises to be of great diagnostic value, and often, too, as a valuable adjunct to treatment in certain cases. I refer to ureteral catheterization. Pawlik, of Prague; Sänger, of Leipsic, and Kelly, of Baltimore, have been recently working simultaneously, but independently of each other, in this line. Kelly's methods, and the catheters he has devised, are simple, and the *technique* can easily be acquired.

On my return to Chicago I saw a woman subjected to nephrotomy by a surgeon of national fame, for supposed pyo-nephrosis of the right kidney. That the pus was not there might have been determined in a few moments by the use of the ureteral catheter, thus saving the patient much risk and misery, and the surgeon some chagrin.

I observed that there is a growing prejudice against neurectomy for intense trigeminal neuralgia, as recurrence seems to be as frequent as after the less severe operation of nerve-stretching. Removal of the gasserian ganglion offers the only permanent relief from this excruciating affection, and will be the operation of the future for obstinate pain of trifacial origin.

There are many other matters of interest that I noted on which I would like to touch sufficiently to evoke your opinions on unsettled questions, but I realize that time is too limited to permit of an extended discussion this evening.

Regarding the personnel of the profession as I found them, I must confess that I was much disappointed in some whom it might be imagined would be ideals, but who are sadly affected with pomposity, egotism, and and petty jealousies. The prevalence of these evidences of mediocrity in high stations in our calling is much to be deplored, and is sufficient proof that we have not yet attained a high degree of perfection.

This matter is too delicate to permit of personal mention or individual comparison, but I cannot refrain from remarking that if we divide the leaders of the profession into two great classes—medical and surgical—we must conclude that the above-named undesirable traits largely predominate in the scalpel manipulators. The strut and bombast of a few of these blade-wielders of the surgical arena is in painful contrast to the modesty and earnestness of their generally more scientific brethren.

DeKum building, Third and Washington streets.

THE SURGICAL TREATMENT OF APPENDICITIS.

By T. W. HUNTINGTON, M.D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal.

Read before the California Northern District Medical Society.

The time has arrived when it is unnecessary to discuss the propriety of a resort to operative measures for the relief of a considerable proportion of cases of appendicitis. The favorable results attained by many operators have conclusively demonstrated that the danger attending the procedure is insignificant, and that very often the pathological conditions are such as to render radical interference imperative. In a word, the operation for the removal of the appendix vermiformis stands accredited as one of the most useful in the entire category.

The changes that may occur as a result of disease of this organ are quite numerous. In the catarrhal variety, its walls may be thickened, softened, and so disorganized as to be torn or broken by slight violence; again, the walls are found distended and thinned by an accumulation of fluid, mucous or muco-purulent in character. Where the trouble originated in the lodgment of a foreign body, the substance may be tolerated for an extended period, and we have it upon excellent authority that autopsies have disclosed foreign bodies in comparatively healthy appendices, with no history of attendant complications due to their presence. When inflammation ensues upon such source of irritation, there may be a rapid culmination and explosion or rupture during the first attack; or the process being less formidable, adhesions to adjacent structures form a protective wall. An abscess eventually results; the contents of which, thus hemmed about, finally escape through one of the several channels.

There can be no doubt that in a certain number of cases spontaneous recovery takes place, after one or more exacerbations. This probably occurs in the milder catarrhal variety, wherein the disturbance subsides before palpable organic changes have been produced. In a very large proportion of all cases there is a strong tendency to recurrence. Pathological conditions result, and the patient with his health undermined lives under a constant menace.

The question when to operate for the relief of this condition is difficult of solution, and it is evident that no general rule can be established as an invariable guide. Each case must be a "law unto itself," and the surgeon must proceed under the dictates of his own judgment. In this, however, as in nearly every surgical emergency, we will do well to bear in mind the aphorism of Jonathan Hutchinson: "Early operations are successful operations." Considering the frequency of this condition in all classes, and at all ages, it seems a little strange that operative measures for its relief are not resorted to more often. Is it possible that the profession, partly through inexperience, and partly through failure to appreciate the pathological importance of the disease, has been delinquent in failing to grasp opportunities when presented? Certainly the difficulties attendant upon the procedure ought not to deter the average practitioner from assuming such a responsibility.

After a moderate experience in dealing surgically with this disease, I have settled a few points with a degree of definiteness that has afforded me much satisfaction. For the present, at least, I am prepared to operate in every case wherein the following conditions exist:

1. When a permanent tumor is present, located at or near McBurney's point.
2. When there is localized pain, either with or without a tumor, continuing during the interval of attacks.
3. Where there is persistent and obstinate constipation, suggesting the probability of obstruction in the bowel. Under such circumstances we have almost positive assurance of the existence of extensive adhesions, crippling more or less seriously the function of the intestine.
4. Where there is a fluctuating tumor denoting the presence of a circumscribed abscess.
5. When in the comparatively rare, fulminating, or explosive cases, septic conditions have been established within the peritoneal cavity, and without operation a fatal termination has become almost an assured fact.

In the selection of a time for operation, there can be no doubt that the period of quiescence affords the greatest immunity from danger.

During the progress of an attack, the patient's condition is that of an invalid. The skin is dry, the abdominal walls are distended, and the relation of parts distorted. At such a time asepticity is, at best, but imperfectly attained; as a consequence, repair of the operative wound is delayed and perplexing complications become possible. On the other hand, during the period of quiescence the patient is in the enjoyment of comparative health, and is in every respect capable of coöperation with the attendant. The most elaborate preparation, both general and special, can be made and no prophylactic measure need be omitted.

The *technique* of the operation is comparatively simple, requiring no elaborate armamentarium, nor more than ordinary knowledge of surgical methods. The choice of the seat of incision, while of no great importance, has been made the subject of considerable comment. A few choose the median line; others the outer border of the rectus muscle. The line two inches above and parallel to Poupart's ligament has very respectable advocates; while probably the larger number of operators open the abdomen by a slightly curved line midway between McBurney's point and the right anterior superior spine of the ilium. Personally I prefer the latter, though in a large majority of cases the exact location of the incision is probably unimportant. The advantage of the lateral incision in the presence of an abscess is apparent.

As a rule, the head of the colon, and with it the appendix, will be found engaged in an elaborate network of adhesions, which must be carefully broken up before further progress can be made. In accomplishing this object, the operator will have ample opportunity for the discovery of any portion of the small intestine that may be constricted or obstructed. The appendix having been liberated, it should be examined with reference to the presence of a considerable amount of fluid; if it be perceptibly distended and its walls consequently thinned, it will be a wise precaution to remove the fluid by aspiration, as an initiatory step. Had this course been adopted in the second case reported below, an awkward accident would have been avoided. The organ may then be ligated near its origin and removed, Much has been said with reference to the treatment of the stump, but in my opinion, the point is unimportant. I have usually cleansed it carefully and returned it without special measures for its protection.

In the uncomplicated aseptic cases, the parietal wound may be closed without drainage. The drainage tube in these cases is superfluous if not absolutely harmful, in that it is liable to entail an obstinate sinus, which weakens the cicatrix, and enhances the possibility of a hernia. The management of a pus cavity resulting from an exploded appendix is quite a different matter. If pus has accumulated so rapidly as to preclude the formation of a protective wall, general septic peritonitis will have been established at the outset and save in very rare instances a fatal termination will ensue. If, on the contrary, a firm wall composed of agglutinated intestine and omemtum has afforded an efficient barrier, the pus may be evacuated, the cavity carefully cleansed, irrigated, and packed with iodoform gauze with a fair prospect of a favorable issue. In this event it is an unwarrantable measure to search for the appendix, the hope being that what remains of it will be securely buried and its identity lost in the process of healing by granulation. Even where there have been prior evidences of intestinal obstruction, I believe it will be safer to take the chance of subsequent trouble from that cause, than to run into the greater danger of carrying fatal infection into the peritoneal cavity. This policy was successfully carried out in the third case reported below.

Attention to the bowels after the operation merits brief consideration. It is my practice to administer a half dozen minute doses of calomel on the second or not later than the third day, following it by rapidly repeated drachm doses of sulphate of magnesia. This never failed of a most satisfactory evacuation and consequent benefit to the patient. The use of opium, save in occasional doses, cannot be too strongly condemned.

The following cases, three in number, each admirably illustrates a separate type of the disease, viz.: Relapsing Appendicitis with intestinal obstruction, due to adhesions. Relapsing Appendicitis of the catarrhal variety, with threatened rupture of the organ. Fulminating Appendicitis, with attendant perityphlitic abscess. They are the eighth, ninth and tenth cases operated upon by me. Of these ten cases eight have recovered; two were operated upon during the progress of general septic peritonitis, and both died. Five of the eight cases underwent operation during the quiescent period, and in each instance recovery was rapid and uninterrupted.

Chronic Relapsing Appendicitis.—H. A. H——, a little girl, six years of age, residing at the Dalles, Oregon. In July, 1890, when three years of age, she was very ill for three weeks. At this time there was high fever, obstinate constipation, great tenderness in right iliac region, and pain which was so severe as to require frequent doses of morphine. After the attack subsided, the tenderness continued some time, and patient lay in bed with the right leg partly flexed. Since then, at varying intervals, there have been twelve seizures similar to the first. In each instance the onset has been sudden and severe, and the symptoms always ominous. During the attack, and at other times, there has been great difficulty in evacuating the bowels. Much of the time tenderness was present at McBurney's point. The last attack occurred July 13, 1893. This was just as severe, but not quite as long as some others. The bowels were evacuated after the third day, by small doses of calomel and repeated enemas. Patient arrived at Sacramento August 1, 1893. On examination, I found a resistant, but illy defined, mass in the right iliac fossa. She refused to talk, and cried constantly during examination, whether from pain or fear I could not determine; diagnosis, chronic recurrent appendicitis. Operation decided upon. August 2d, assisted by Drs. H. L. Nichols, Hanna and Birdsall, ether was administered, and the abdomen opened by a lateral curved incision, two inches in length. The parietal peritoneum was found thickened and converted into a strong, fibrous membrane. On opening it, a coil of the small intestine, reddened and inflamed, quickly protruded. After a short search, the head of the colon was discovered, and a most interesting condition of things revealed. At the fundus of the caput coli, two separate coils of small intestine were found adherent to each other, and firmly attached to the colon, the mass thus formed enveloping and concealing the appendix. The entire tumor was encircled by many strong bands. After carefully separating the adhesions and freeing the bowels, the appendix was found to have been torn across, only a short stump remaining; this was ligated and cut away. The distal portion was not found. The protruding bowel and omentum was reduced and the parietal wound closed with three silk sutures. On the second day, the bowels were moved, according to the plan before alluded to. The sutures were removed on the seventh day, and on the fourteenth day the child started on her home journey. Very recently I have been advised that she continues in perfect health.

Chronic Relapsing Appendicitis.—W. T——, aged 30 years; a railroad station agent, residing in Siskiyou county, Cal. For the past two years has had pain and tenderness in the right iliac region. On March 28, 1893, he had a sharp inflammatory attack involving the same area, which lasted several days. On May 11th he had a much severer attack, which laid him up for three weeks. Tenderness persisted until July 15th, when he had a third attack, lasting two weeks. Subsequent to this there has been a tumor in the right iliac region. August 7, 1893, patient entered the Southern Pacific Company's Hospital. At this time there was a perceptible tumor, pain and tenderness, as above stated. August 9th, the usual operation for removal of the appendix was done. The external incision being 2½ inches long. The omentum was found extensively adherent to the parietes as a result of former inflammation. The cecum was bound down by firm adhesive bands. The bowel having been released, the appendix was discovered greatly distended by pent-up fluid. In attempting to bring the cecum and appendix out of the cavity, the latter was ruptured, and its contents, which consisted of muco-purulent fluid escaped. Fortunately, however, the abdominal cavity was protected, and the material was received upon cotton and gauze. Upon further manipulation, the appendix was torn from its attachment without ligature. Its point of origin was covered by stitching over it the edges of the peritoneum. The operation was concluded as usual. Aside from a small parietal abscess in the line of incision, which may have been due to the accident above described, there was no interruption to rapid recovery. The case was well on the twenty-first day.

Fulminating Appendicitis Resulting in Perityphlitic Abscess.—E. M——, aged 25, a Spanish laborer, entered the hospital September 26, 1893. Patient states that this is his first illness. For the past ten days has suffered great pain in right iliac region. During this time the bowels have moved regularly. On examination, there was a perceptible tumor in the right iliac region, attended with marked elevation of the parietal wall, and intense pain and tenderness upon manipulation. Temperature, 101° F. The patient was at once prepared for operation, which was performed on September 28th. On opening the peritoneum through the usual incision, there was a sudden gush of the most fetid pus imaginable, and fully eight ounces in amount. The wound was then slightly enlarged, and upon exploration I soon discovered lying loosely in the cavity a firm fecal concretion the size of a large white bean. The cavity was then carefully cleansed by scraping its walls with the finger nail, and by prolonged irrigation with sublimate solution. For reasons previously given, no special effort was made to locate or to remove the appendix. The abscess cavity was freely dusted with iodoform, and firmly packed with iodoform gauze. The parietal wound was left open and a liberal dressing applied externally. Since the operation the packing has been removed every other day. At no time has there been detected any fecal odor or other evidence of intestinal perforation. The temperature has been normal most of the time, and has never risen above 100° F. At the present time (October 12th) the wound is clean, discharge insignificant, and its walls are covered with healthy granulations. At no time has there been any difficulty in securing an evacuation of the bowels. The patient will undoubtedly recover after a prolonged convalescence.

An important point, bearing upon the diagnosis of appendicitis, has recently been made by an eminent authority. It has been shown conclusively that the subjective signs are not always commensurate with coincident pathological conditions. On the other hand, Richardson, of Boston, reports attacks occurring after removal of the appendix, which closely resembled those preceding it. This statement will bear close scrutiny, and we shall await further developments in operated cases with much interest.

426½ J street.

SOME CASES OF LAPAROTOMY.

By A. MILES TAYLOR, M.D., Oakland, Cal.

Read before the Alameda County Medical Association.

The following case reports represent a series of abdominal sections performed at my private hospital in this city. Believing that they present some points of interest in diagnosis and treatment, I have ventured to submit them, without comment, to the Society this evening.

Case I,—M. B——, aged 61 years; had been treated in Victoria, B. C., and Seattle, Wash., for some obscure pain in pelvis, which had grown worse within the past six months. The abdomen had enlarged very rapidly during the last two months. On examination, I found an ovarian cyst of large size, which resembled a pregnant uterus of seven months. Operation was advised, to which she consented. I opened the abdomen, and found a simple cyst of the left ovary. This was tapped and the contents drawn off, the pedicle was tied and dropped, the cavity washed out with hot water, and the abdominal wound sutured. The patient made a good recovery, with the exception of two stitch hole abscesses, and returned home the twenty-eighth day after operation.

Case II.—J. Mac——, aged 30, two children, two abortions. She had been treated in Utah for several months for painful menstruations but without success, the pain returning and increasing with each period. On examination, the left ovary and tube were found enlarged, displaced, and very painful to touch. Quite a discharge of pus was noticed after the menses. Bladder irritable and micturition painful. Removal of the diseased organ was advised. The abdomen was opened and the ovary and tube removed. The other ovary was examined and found healthy. The stump was dropped and the wound sutured, after washing out the cavity with hot water. No drainage tube was used. Recovery was uninterrupted and patient went home in five weeks, well.

Case III.—M. H——, 29 years of age. Had had two miscarriages (both produced by means of sound), the last one seven months ago, from which time she has suffered with pain in right side of pelvis, worse at time of menstruation, which was irregular. On examination, I found an enlarged tube and ovary. The uterus was prolapsed and about the size of a small cocoanut. Laparotomy was advised and was done the following day. On opening the abdomen, many adhesions were found, which were broken up and the ovary brought out. In doing so a cyst was ruptured, and the cavity flooded. The ovary and tube was removed and the pedicle tied and dropped. The left ovary appeared to be sound. Washed out cavity with hot bichloride solution (1:5000), and sewed up abdominal wound. Patient did well until the third day, when the temperature rose to 103° F.; pulse, 135. Three hours later patient had a copious evacuation and the temperature immediately dropped to 100°. The following morning the temperature was 99½°, and from this time on patient made a rapid recovery.

Case IV.—M. M——, aged 34 years; no children; one miscarriage, eight years ago. For the past seven years has suffered constantly from abdominal pain. I saw her in February, and found she had been confined to her bed for eight weeks, with a general peritonitis. Opium, belladonna and hyoscyamus was given in the form of suppositories, *per vaginam*, and mercurial ointment, by inunction, to the abdomen. In ten days an examination was made, and the left ovary found enlarged and quite tender. I treated patient for four weeks, and then operated. Found many adhesions and the tube full of pus. The ovary was in places hard and nodulated, in others sacculated, the cavities containing pus and broken-down tissue. Removed tube and ovary and washed out cavity, when I found considerable bleeding. Further search showed that this was from the separated adhesions. Several bleeding points were tied and the hemorrhage ceased. Washed out cavity again and sutured wound without drainage. Patient made a good, but slow, recovery. She then went east, and, on returning, I was called in, when, to my surprise, I found the uterus as large as a four-months' pregnancy, and pressing on the rectum so that it was with difficulty she could evacuate the bowels, unless when using enemas. The remaining ovary was enlarged and wedged down in the pelvic cavity. A vaginal examination showed the cervix had a livid, congested appearance, and the patient the cachexia often seen in cancerous persons, which I now believe was the pathological condition existing in the ovary removed some months ago.

Case V.—N. C——, aged 32; one child. Had ovaries removed four years ago by Dr. Vanderveer, of Albany, N. Y. Two months ago I was called in, and found patient slightly delirous and having great pain about the pelvic region. On examination, a large tumor was discovered in the *cul-de-sac;* the uterus was somewhat enlarged. Placed her on opium and belladonna suppositories and used glycerine and iodine, *per vaginam*, but the pain continued and increased. Advised patient to go to hospital and submit to an operation. Eight weeks ago, assisted by Drs. Olmsted and Eastman, I opened the abdomen and found the tube prolapsed, with a large cyst attached, filled with dark, broken-down tissue; also, an enlarged fibroid uterus. The uterus was removed by amputating at the cervix. Washed out cavity with hot water, and sutured abdominal wound. With the exception of one small stitch-hole abscess, patient made a good and rapid recovery. There was some discharge from the vagina which persisted for four weeks; on examination, I found my ligature (which was silk) had been thrown off through the remaining cervical canal, or through the vaginal wall, though no trace of a sinus could be found in the latter.

Case VI.—M. J——, aged 24. Has been an invalid for eight years. She suffered from pain commencing in the stomach and extending to the entire left side of arm and leg. She stated that a place in the epigastrium about two inches in circumference would burn constantly during these pains, which sometimes would cause spasmodic contraction of the muscles of the arm and leg of the left side, occasionally extending to the right. The left leg would sometimes become so bad that to extend it would cause great pain. These pains would last from one to three hours, and would come on generally after taking something into the stomach; even water or milk might produce the attack. She stated that she had had "fever" daily for seven years, which would come on periodically from 1 to 2 P. M., and last for two or three hours. During this period her face would flush, and occasionally she would vomit. When I saw her, about 2½ years ago, she had been in bed for eight weeks, and had not been able to retain any food for five weeks, being sustained wholly by enemas. She was constipated and very emaciated. I placed her on kumyss, bismuth, etc., and after three days she was able to retain food, gradually improving. In three months she was able to eat almost anything without pain; yet the afternoon "fevers" continued. She became regular in her menstruation, which was painless. She remained about the same until five months ago, when she went to Los Gatos to spend a few weeks, but returned in ten days prostrated, vomiting, and in great pain at the place that had been burning at the stomach. Kumyss and other preparations that had formerly given relief could not now be retained, and it was decided to make an exploratory incision in the epigastric region, which was accordingly done three weeks ago. On dissecting carefully through the abdominal wall I found the peritoneum bound down to something. The adhesions, which were attached for two inches in circumference, were broken up and the stomach found engaged in them. After further dissecting I removed a small flat tumor, somewhat larger than a silver dollar, and about half an inch thick. Whether this had started from the stomach or from the parietal wall could not be determined, but I believe it originated in the former. The cavity was washed out with hot water, some adhesions tied and the wound sutured. The temperature never rose above 99° F., and on the fourth day I removed the sutures, union being perfect. The patient seems entirely relieved from all the symptoms, except the "flushes" in the afternoons, which are, however, less severe. She eats all kinds of food without any pain, and has gained two pounds since the operation. The liberating of the stomach from the parietal wall by the breaking up of adhesions, and the removal of this small tumor, will prove a great benefit, if not an entire cure.

Case VII.—N. L——, aged 35; married; one child. Several years ago contracted syphilis, which was not treated for some time, and then only locally. Has suffered constantly for eight years with pain in pelvis. I first saw her three years ago when she had an attack of *la grippe*, from which she never fully recovered. Has been confined to her bed for about two years. Twenty months ago I attended her in an attack of general peritonitis, from which she soon recovered. Subsequently she had an offensive discharge from the vagina, a slough coming away that resembled a tube. I saw her a few days after, with Dr. W. E. Taylor, and advised the removal of tubes and ovaries, which were perceptibly enlarged and thickened, but she would not consent. Three months later, she had another attack of peritonitis, followed by a similar slough, and a month later the same condition of things occurred with the exception of the character of the slough, which this time resembled the interior of the uterus. She lost strength and gradually grew weaker. Six months ago her abdomen became swollen to a great size, the pain being unbearable. I punctured, through the vagina, what seemed to be a cyst, when at least a gallon of fluid came away. The patient rallied and for six weeks or two months was much improved, when the same condition returned. This recurred again, when I was asked to operate. After informing the family of the great danger attached to such an operation, I operated November 5, 1893. The ovaries, tubes, and uterus were removed, the cervix being amputated at the vaginal junction. Adhesions were encountered everywhere; the broad ligaments were extensively diseased and almost sloughing. Patient rallied from the operation, but began vomiting, which could not be controlled, and died on the fourth day. I opened the abdomen *post-mortem* and found a general peritonitis. The stump was clean and had begun to heal. I am satisfied, that had the vomiting been controlled, the patient would have recovered.

Case VIII.—R. S——, aged 26 years, No history of specific trouble; has suffered from pain in the region of the liver and spleen for three years, On examination, found nodules of liver and a large tumor of the left side, believed to be an enlarged spleen. The pain was unbearable at times, and patient had, in consequence, acquired the morphine habit. There was also a space on the left tibia that was enlarged and painful. The man had been an invalid for a long time, and had been variously treated. I advised an exploratory laparotomy, to which patient consented. Assisted by Drs. Baldwin, Eastman, and Grazer, I opened the abdomen and found the liver much enlarged, with nodules as large as hens' eggs on edge and under surface. The spleen was also enlarged to double its normal size. The encroachment of the spleen upon the diaphragm and heart impeded respiration and disturbed the cardiac action, while a large amount of dark fluid was found in the peritoneal cavity. This was sponged out and the wound sutured. Patient was placed on iodide of potassium and biniodide of mercury, and began to improve. At this writing, the splenic enlargement is scarcely perceptible, the nodules on the liver are disappearing, and the tibia is normal in size and painless. Patient has ceased the use of morphine, and has gained 30 pounds in weight.

Case IX.—W. M——, aged 31 years. Has been sick for seven months. Lost flesh rapidly; severe pain in left illiac region; large and frequent hemorrhages from bowels, which leave him blanched and weak. Patient has been treated by local physicians for piles and catarrh of the stomach. On examination, a large and movable tumor was found in the left illiac region. No rectal trouble could be discovered. Placed patient on lead, opium, and ergot; and saw him again in two weeks with Dr. Theo. Olmsted. The hemorrhages had been less frequent, but the tumor was still apparent. Patient was daily growing weaker, and desired me to open the abdomen and try to give him relief. Assisted by Drs. Olmsted, Eastman, and Grazer, I operated and found the viscera adhering to each other and to the parietal peritoneum to such an extent that it was impossible to introduce the finger anywhere without breaking up adhesions. This was done and an attempt made to reach the tumor. This was found in the descending calon, and on manipulation it disappeared, *per rectum*, in the form of clotted blood. After breaking up more adhesions the wound was cleared. Patient was placed on antisyphilitic treatment, although there was no specific history. He improved, and left the hospital in four weeks. He has had no hemorrhage since the fifth day after operation; has gained in weight and feels much improved.

Case X.—M. B——, aged 65 years. When 14 years old suffered from psoas abscess, which was treated in England. Eighteen months ago I was called in and found him with a temperature of 105° F.; pulse, 130, and marked tenderness over right lumbar region and in front of crest of ilium. A free incision was made in the lumbar region and about half a gallon of very offensive pus evacuated. The cavity was packed with iodoform gauze. In connection with Dr. Theo. Olmsted, the case was treated for some weeks when patient, seeming about well, went back to work, and later, to Southern California. About nine weeks ago he came to my office, and on examination, I found that the region in front of the ilium and above Poupart's ligament, was very tender to touch, red and swollen. Patient said the discharge had commenced again at the old opening, but had suddenly ceased three or four days before, and since that time there had been great pain over the abdomen, and general swelling. I advised him to go to the hospital where I would open up the old sinus and see what could be done. The following day, assisted by Drs. Olmsted and Eastman, I exposed the sinus, and found the pus had burrowed in front of the ilium, and formed a pocket as large as the fist, which had ruptured, allowing the contents to escape into the peritoneal cavity. An opening was made in front about three inches long, commencing at the crest of the ilium and following in the line of Poupart's ligament. A large amount of pus and pyogenic tissue was evacuated, the old abscess cavity was curetted, the abdomen washed out and the peritoneum sutured. A counter opening was left at the lower edge anteriorly and the wound packed with iodoform gauze, through from back to front. Patient did well, the peritoneum healing kindly. The wound was dressed every second day by irrigating with carbolic acid solution and applying iodoform gauze. Now there is no discharge and only a small sinus, opening posteriorly, remains, the opening in front having healed.

Since the above report this case has entirely recovered:

Case XI.—F. F——, aged 33; married; no children. Had pain in back and left side for three years and had been treated and advised to have an operation, in Germany, where she then lived. On October 27, 1893, she was seen by Dr. J. S. Eastman, of Berkeley, who found her having rigors, with a temperature of 103° F.; pulse, 120. He made an examination, and found a large fluctuating mass in the region of the left tube and ovary; the uterus was also enlarged. A few days later I saw her, in consultation, and advised her to come to the hospital and have the diseased organs removed, to which she consented. November 8th, assisted by Dr. Eastman and Dr. Olmsted, I opened the abdomen in the median line and found the uterus much enlarged and the left tube and ovary diseased; a sac connected with the left ovary containing about three pints of pus. The right ovary contained several small cysts. The entire mass was adherent and bound down to the rectum and other viscera to such an extent that, in manipulating the mass, the sac ruptured, allowing the pus to escape into the peritoneal cavity. After breaking up the adhesions I removed the entire mass (uterus and ovaries), amputating at the cervical junction, not covering the stump with peritoneum, but tying it off in sections and dropping it. Many bleeding adhesions were tied and the abdominal cavity thoroughly washed out. The abdomen was closed, a drainage tube being inserted. The following day quite a quantity of fluid was withdrawn through the tube, and the abdomen washed out, through the tube, with a solution of lysol. This was kept up for several days, until no discharge was found. Patient gained rapidly, and three weeks after the operation went home to the country.

The result of the above cases is additional evidence of the well-established fact that private hospitals are vastly superior to public institutions or homes for abdominal surgery.

Thirteenth and Clay streets.

A CASE OF CHOLECYSTOTOMY, FOLLOWED BY CHOLECYSTOENTEROSTOMY BY MEANS OF MURPHY'S BUTTON.

By Geo. Franklin Shiels, M. D., F. R. C. S. E., Professor of Surgery, Post Graduate Department of the University of California, etc.

Read before the California Academy of Medicine.

Gentlemen: I crave your attention for a few moments this evening to a case of cholecystotomy, followed by cholecystoenterostomy, which seems to me to be of interest.

Wong Lai, a Chinese, aged 55, presented himself to my friend, Dr. G. L. Fitch, suffering from a spasmodic, colicky pain to the right of the umbilicus, but on a slightly higher level; the pain radiated from this point over the anterior abdominal parietes. Examination showed the presence of an oval elastic tumor, to the right of the median line and slightly below the umbilicus, which was larger than a man's fist. The skin was of a lemon color, the conjunctivæ bright yellow and the stools like putty. Percussion and palpation showed the liver to extend three inches below the free costal margin.

I was called by Dr. Fitch in consultation, and through our kindly interpreter, Mr. Chan Hon (assistant pastor of the Methodist Chinese Mission), we elicited the following additional facts: The patient had been suffering from irregular attacks of colic for two months, and had been jaundiced during the greater part of the time. We could get no history of the passage of gall-stones. The general appearance of the patient in no way suggested cancer, he being well nourished, bright and cheerful.

A diagnosis of impacted stone in the common duct was made. Morphine was administered and controlled the pain. Mercurial cathartics were given, but had no effect in changing the color of the stools or in relieving the jaundice. As it was evident that the patient could not live and remain in his present condition, we were forced to suggest the necessity of operative procedure, in which he at once acquiesced.

October 13th, under circumstances and in surroundings which allowed of anything but detailed aseptic precaution, we proceeded to perform the first operation—cholecystotomy. An incision 2½ inches long was made over the most prominent portion of the tumor, the peritoneal cavity opened, and after a little manipulation the fundus of the enormously distended gall bladder was brought up into the wound. After stitching the skin to the parietal peritoneum, the gall bladder was fixed in the wound by a series of interrupted sutures, as a continuous one was thought unnecessary since the bladder seemed to force itself into the opening. Two days later, firm adhesion by plastic lymph had occurred, and the peritoneal cavity was thoroughly closed off.

The second step was now undertaken. An incision large enough to admit the forefinger being made into the gall bladder, instantly there was a gush of bile, more than a pint escaping. On sponging the wound, we discovered that there was an alarming hemorrhage from the edges, which continued, and was only controlled by the use of the actual cautery. No stone came away with the bile, and careful exploration with finger and sound failed to detect the presence of a calculus. We attempted to pass a probe into the cystic duct, and thence into the common duct, but did not succeed because of inability to reach the entrance of the cystic duct on account of the enlargement and distortion of the bladder.

With a feeling of disappointment (and in case the patient did not improve with the intention of further operative procedure), the wound was dressed, placing a large amount of absorbent cotton over it to take up the bile, as it escaped, and leaving instructions that it should be frequently changed to avoid irritation of the skin, which I may say here, never occurred.

The patient reacted well, showing great vitality, and on the evening of the second step of the operation he complained of feeling hungry (the first time for weeks), and was given a broth made of rice, which is a favorite article of diet among the Chinese. At first there was some slight improvement in the jaundice, but it did not continue, and the patient rapidly emaciated.

Still holding the case to be one of impacted gall-stone, and believing that the patient was suffering from "bile starvation," on October 26th we decided on a second operation, that of cholecystoenterostomy, with a view of establishing a passage for bile into the duodenum, and then closing the fistula left by the cholecystotomy. A hypodermic of $\frac{1}{80}$ of a grain of strychnine sulphate being administered the patient was chloroformed, and the following operation performed:

An incision beginning four inches above the umbilicus, and extending downwards around and past the umbilicus, brought us to the peritoneum, which was opened after arresting the hemorrhage. This gave us an excellent opportunity for exploration, and, though we made use of it, we failed to detect the real cause of the mischief, which was only demonstrated by the *post-mortem* examination. All the ducts, the cystic, the hepatic, and the common duct were greatly distended, and there was a peculiar doughy feeling of the common duct, much like that of a tube filled with putty.

Time being an object, and the patient showing signs of collapse, we hastened to complete the operation. A finger introduced through the fistulous opening in the gall bladder brought it well into the median incision. An opening being made, one-half of a medium-sized Murphy's button was introduced and fixed in position by the usual procedure, While an assistant held it in position the duodenum was sought for, and, as we thought, found, and brought up into the wound, opened, and the other half of the button placed in position. The two halves of the button were now forced together, and the anastomosis between the gall bladder and the intestine was completed.

As there had been little or no hemorrhage, and no fouling of the peritoneal cavity, we next closed the median wound, dressed it, and placed the patient in bed. After this operation the patient again rallied well. His temperature remained below 100° F., and his pulse was strong.

The day following, there was ileus and tympanitis, which disappeared upon the administration of 10 grains of calomel. The median incision healed, but there were a couple of stitch-hole abscesses left on removing the sutures.

October 28th, the edges of the fistula in the gall bladder were freshened, and a running suture used to bring them together. October 29th, this suture was broken down, and bile, flatus, and half digested food escaped from the opening. Examination showed that the opening into the intestine was quite patent, the button having found its way into the bowel some five days after the operation. In spite of this, there seemed to be an obstruction to the flow of bile into the intestine, as it continued to flow freely from the external fistulous opening. The profound jaundice continued, the patient progressively emaciated, and eventually died on November 9th.

Autopsy: On the day following, Dr. Fitch performed a hurried autopsy, as the relatives were about to arrive and he knew that they had a strong feeling against the procedure. The following points were demonstrated: The liver was congested, enlarged, and bile-stained. There were no signs of peritonitis. A smooth, round opening was found between the gall bladder and the jejunum (not the duodenum as we had supposed), about 14 inches from the pyloric end of the stomach. At this point there was a kind of reverse intussusception which prevented the free flow of bile into the intestine. The head of the pancreas was found to be enlarged and infiltrated with cancerous deposit which pressed into the curve of the duodenum and thus closed off the common duct, being aided in doing this by an extremely congested and edematous condition of the mucous membrane of the duct and of the duodenum in the neighborhood of its opening. All other organs of the abdomen were healthy, though deeply bile-stained.

We had intended securing the specimen, but at this point a knock on the door apprised us of the arrival of the relatives, so we were forced to hastily close the *post-mortem* wound, losing the button, which was in the intestine, as well as the specimen.

I wish to direct attention to the following points in this case, which are of interest:

1. The mistaken diagnosis of stone, all symptoms of stone being present, and all symptoms of the real condition, cancer of the pancreas, being absent.
2. The enormous distension of the gall bladder, which did not allow of complete exploration even after the bile (more than a pint) had escaped.
3. The peculiar doughy feeling of the common duct, produced by edema, and not soft gall-stones as it would suggest.
4. The reverse intussusception in the bowel at the point of anastomosis, which acted as a valve, preventing the flow of bile from the gall bladder.
5. The alarming hemorrhage from the small wound in the gall bladder, which has already been noticed by Dobson to be found in jaundiced individuals.

6. The wonderful resistance to shock and septic infection shown by the patient.

7. The use of the Murphy button in accomplishing the anastomosis.

In this connection I must say that I do not believe this device to be in any way useful for intestinal anastomosis for very many reasons, chief of which is the after contraction, which I pointed out as a danger when the button was first used, and which has since been clearly demonstrated by Prof. Dawbarn, of New York, whose experiments show it to be over 75 per cent. This effectually condemns it for lateral intestinal anastomosis.

In cholecystoenterostomy, however, the objection does not hold, since we only require a very small opening for the biliary flow, and by using the medium sized button and allowing for 75 per cent. of contraction, we still have an opening which is amply sufficient. The ease of its application and the perfection of the anastomosis are the two great points in its favor.

Let me say, in closing, that I believe this is the first instance in which these two operations have followed each other, and that I believe if the case had been one of stone, that we would have had an excellent result, an opinion which was endorsed by the *post-mortem* examination.

32 O'Farrell street.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M. D., Sacramento, Cal., and

HENRY GIBBONS, JR., M. D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Permanganate of Potash in Gynecology.—While the first effect of nitrate of silver, and of sublimate, is to set up free suppuration of the urethra, a suppuration which furnishes an excellent medium for the gonococcus; permanganate of potash excites a serous discharge very different from the usual discharge in blenorrhagia, which sweeps away the microbes already present, and prevents the development of others. This was proved by the fact that bacteriological examination of the urethral discharge after injections of sublimate and of permanganate, showed the presence of a large number of gonococci in the first case and none at all in the second. M. JANET concludes from these experiments that permanganate is a specific for the microbe of blenorrhagia, and profoundly modifies its culture medium. DR. MONOD recommends its use whenever the uterus is infected. In 10 cases of endometritis in nuliparæ he swabbed the inner surface of the cervix, or of the uterus whenever possible, with a solution of permanganate (1:1000) which was, in every case, followed by a diminution of uterine discharge. Two other patients suffering from metritis, with salpingitis of undoubted blenorrhagic origin, were greatly benefited by daily injections of the same solution. After dilatation of the cervix, injections may be given of the same solution used by Janet (1:1000). Dr. Monod suggests that medicated crayons might be applied, but he has not yet used them.—*Gazette de Gynécologie*, November 1, 1893.

Uterine Retroflexion and Gastric Neurosis.—Nearly all physicians at the present time, diagnose gastric disturbance, when accompanying uterine retroflexion, as a complication of the displacement, or a reflex neurosis, without examining the stomach itself. It not unfrequently happens that relief of the retroflexion does not relieve the gastric disturbance, and in view of this fact DR. A——, examined the stomach in 15 patients. In 11, in which gastric pain was the principal symptom, the quantity and quality of food taken had no effect upon its duration and intensity, while digestion went on with regularity. Rest, and maintenance of the uterus in place, afterward effected a cure in 8 of these cases, without the use of other remedies, but gynecological treatment had no effect upon the other 3. Organic or functional derangement of the stomach was found in the remaining 4. Although the small number of patients examined will not justify definite conclusions, Dr. A—— believes: (1) That gastric disturbance accompanying uterine retroflexion should not always be regarded as a reflex neurosis. (2) That if gastric symptoms continue after the relief of retroflextion, it is necessary to examine the stomach itself.—*Annali di Ostetricia e Ginécologia*, October, 1893.

Chronic Mastitis and Cancer of the Breast.—The diagnosis of chronic mastitis and of cancer of the breast is extremely important. In chronic mastitis a simple operation assures relief. In cancer, the total removal of the breast, and complete clearing of the axilla, if diseased glands are present, must take place as soon as possible. In order that we may avoid the errors of Benj. Brodie, Astley Cooper, Dupuytren, Velpeau and others, every symptom of the two diseases must be carefully considered. M. DE ROUVILLE reports the case of a woman, who had weaned her baby three weeks before, and who wished to be relieved of a tumor of the breast, of moderate size, very hard, very regular, accompanied by extensive axillary adenitis, partial adherence of the skin, but no contraction of the nipple; diagnosis was doubtful; in favor of neoplasm hardness of the tumor, adherence of the skin, axillary adenitis; absolute freedom from pain even upon pressure; in favor of chronic mastitis; the important etiological element, lactation; the remarkable regularity of the tumor and its rapid evolution; and, finally, the *number* and *considerable size* of the diseased glands. The preponderance of symptoms was in favor of mastitis, and an exploratory incision with a Pravaz needle revealed the presence of pus. In every case, says RÉCLUS, in which the diagnosis of cancer is not certain, a Pravaz needle should be plunged into the tumor. The operation may be varied according to the size of the abscess. If it is small, a simple incision, followed by the application of a chloride of zinc solution (1:10) may be sufficient. But, if large, the rigid walls of the sac will not easily lend themselves to union by first intention; simple incision and drainage permit the formation of a fistula, and, later, of an indurated intramammary nodule, and, consequently, whatever its size, it is preferable to remove the entire purulent sac.—*Union Médicale*, November 18, 1893.

A Means of Obtaining, in Cases of Head Presentation, Flexion of the Fetal Head, from the Beginning to the End of the Period of Dilatation.—In cases of head presentation, when the head is insufficiently flexed, and dilatation has begun, but remains stationary, the use of an elastic dilator will tend to hasten delivery and prevent secondary uterine inertia. An empty dilator should be introduced between the forehead and the uterine wall, filled with liquid and held until sufficiently enlarged to remain in place. The obstetrical dilators generally used are designed to bring on labor rather than to act upon the head. Tarnier's dilator is too small and the walls are too thin. The dilator of M. Charpentier de Ribes is large enough and strong enough; but its inelastic walls take, on distension, an invariable form, spreading over the inferior segment, and failing to produce flexion. A large dilator, with strong, but elastic, walls, analogous to Ganel's vaginal pessary, is the dilator required. May not such an artifice be generally used? May we not, to the great benefit of the patient, avoid waiting until dilatation is complete, in order to rectify a face presentation or to flex a presentation of the head? May we not, by reducing various inclined presentations, save the patient's strength for spontaneous delivery? Without replying in the affirmative, DR. TOURNEL believes that this reduction, probably impossible in a lateral inclination of the head above a contracted superior strait, is probably obtainable in a large number of cases.—*Journal de Médicine de Paris*, November 26, 1893.

SURGERY.

By T. W. HUNTINGTON, B. A., M. D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and

G. F. SHIELS, M. D., C. M., F. R. C. S. E., Surgeon Post-Graduate Department University of California, San Francisco.

Iodoform and Pus Formation.—DR. MANSEL has made an interesting series of observations (*Bulletin Général de Thérapeutique*) on the action of iodoform in preventing suppuration. He watched the action of leucocytes on a warm stage amongst which a virulent culture of staphylococcus pyogenes had been introduced. A number of the microbes were absorbed by the leucocytes, but the latter were destroyed in about two hours. Dr. Mansel is of opinion that this destruction of leucocytes is due not to any mechanical action on the part of the staphylococcus, but to the toxines evoked by the microbe. Iodoform was then mixed with blood in the proportion of 0.10:0.55 per kilogramme of blood; the leucocytes were not, however, affected by the drug injuriously—on the contrary, the activity of their movements seemed to be increased. In another series of experiments he mixed iodoform with cultures of staphylococcus pyogenes aureus and staphylococcus pyogenes albus, but the organisms underwent no change. He then subjected the leucocytes and cultures of these microbes together to the action of iodoform, and found that the virulence of the staphylococcus was certainly diminished; for, instead of the movements of the leucocytes ceasing in two hours as they did in the first series of experiments, they continued for at least eight hours. An interesting fact was here noted, that although the virulence of the microbes was diminished, and they seemed to be devoured by the leucocytes, yet their reproductive properties were not affected and fresh subcultures were easily obtained..—*Lancet*, December 9, 1893.

Suture of Wounds of the Liver.—At the recent Surgical Congress in Rome, MICHELI (*Riforma Medica*) showed a case in which he had successfully sutured a wound of the liver. Laparotomy having been performed, it was found that the wound was situated on the convex surface of the left lobe near the free margin; it was 4 centimeters in length and 2 in depth, and was directed vertically toward the lower margin of the organ. A moderate amount of hemorrhage had taken place. The edges of the wound in the liver substance were brought together with five silk sutures and the abdomen closed. The patient, a woman, made an uninterrupted recovery, and was discharged, cured, in twenty days. In a case of gunshot wound of the liver, the author applied fifteen silk sutures, and hemorrhage was so thoroughly controlled that no trace of bleeding having taken place could be found four days after the operation, when death occurred from peritoneal sepsis. Other cases, in which wounds of the liver had been successfully dealt with in the same way by his colleagues at the Consolazione Hospital in Rome, were cited by the author. He asked for an expression of opinion from the meeting on the following points: Is suture preferable to plugging with gauze in the treatment of wounds of the liver? Is surgical intervention always justifiable in such cases? In the discussion which followed, MONTENOVESI related some cases in which he had successfully sutured a wounded liver. PACI referred to some cases in which such wounds had been recovered from without surgical intervention, which he considered justifiable only when hemorrhage was profuse; a similar opinion was expressed by SCALZI, who mentioned 16 cases in which his colleague, Postempski, and himself had successfully sutured wounds of the liver. In reply, Micheli quoted the *post-mortem* records of the Consolazione for a period of twenty years, which showed that, during that time, death had occurred from hemorrhage or sepsis in about 20 cases in which wounds of the liver were left unsutured. He explained that the sutures were passed only superficially through the liver substance.—*British Medical Journal*, December 2, 1893.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M. D., Sacramento, Cal.

The Relief of Chronic Deafness, Tinitus, Aurium, and Tympanic Vertigo, by Removal of the Incus and Stapes.—In an article on this subject, Dr. CHAS. H. BURNETT points out the fact that vertigo, due to the mechanical pressure of the stapes upon the labyrinth fluid following chronic catarrh of the middle ear, is usually attributed to "biliousness" or "neurasthenia," or is erroneously called Ménière's disease. Ménière's disease is a form of vertigo, due to disease of the semicircular canal. This disease is very rare and difficult of diagnosis. To call all forms of aural vertigo Ménière's disease, as is frequently done, is a great error. Tympanic vertigo, however, from lesion of the middle ear, is of common occurrence. It is usually accompanied by tinitus and deafness in the affected ear. The severity may vary from a slight unsteadiness in gait to a reeling and falling without loss of consciousness. Sometimes nausea or vomiting occur. That the vertigo is of mechanical origin is proved by the marked relief obtained in the cases reported by the author from removal of the stapes or the stapes and incus. In six cases the stapes, or the stapes and incus, were removed with ultimate entire relief from the vertigo, and marked improvement in the tinitus and deafness. The author concludes: (1) That removal of the retractive force of the sound conductors upon the stapes, is the efficient means of relieving the tinitus, deafness. and vertigo, due to lesions of chronic catarrh of the middle ear. (2) That the removal of the retractive force upon the stapes can be accomplished efficiently and simply by removal of the incus alone, and even by resection of its long process. (3) The improvement in these cases is due to the liberation of the stapes from the retractive power of the tensor tympani muscle, and the consequent unimpeded action of the stapedius muscle, which, relieved of the antagonism of the tensor tympani, tends to draw the stapes from the oval window, thus aiding in the isolation and improved mobility of the bonelets, as well as in removing its undue pressure inward upon the labyrinth fluid. (4) It seems wiser, therefore, in most cases of chronic catarrhal deafness, tinitus, and tympanic vertigo, not to sever the stapedius tendon and remove the stapes, but to be content with removal of the incus only. (5) Removal of the incus alone, the membrane, malleus, and stapes being left *in situ*, gives more space to the drum cavity, *increases its resonance*, and permits freer access of sound-waves to the stapes, thereby improving hearing. (6) Progressive improvement of hearing noted in many instances, must be due to the passive motion exerted upon the ankylosed stapes by sound-waves, which are enabled to reach this bonelet more freely after the removal of incus.—*Journal American Medical Association*, November 1, 1893.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. Simmons, Jr., M. D., Sacramento, Cal.

The Abortive Treatment of Blenorrhagia.—The Paris correspondent of the *Medical Press and Circular*, says: At a meeting of the Biological Society a member communicated the results of his experiments with different antiseptics as to their value in arresting the development of the gonococcus. To this end, he had made for him, a series of wicks made of fine cotton, which he subsequently steeped in the antiseptic liquid, and thus charged he passed them into the urethras of five men who had voluntarily submitted themselves to the inoculation of the virus. The result was perfect, the disease did not show itself after the usual period of incubation. The antiseptic used was a solution of sublimate, and the instrument was left *in situ* two hours. He then inoculated *himself* with a like result.

Solar Erythema.—Finsen states that it was formerly believed that solar erythema was caused by the thermic rays of sunlight, and that the pigmentation following it was of the same origin. Recent investigation by Unna, Widmark, and Hammer, tend to prove that the chemical rays, and especially the ultra-violet ones, are the real agents, and that this seems to be corroborated by the fact that very intense solar erythema may be produced in the arctic regions and on glaciers, where the temperature is below zero. Unna is of the opinion that the pigment of the skin affords protection against the effect of the ultra-violet rays, negroes and other dark-hued inhabitants of the tropical regions suffering less from the effects of insulation than the races of light complexion. In order to prove the protective value of pigment on the skin, Finsen painted with China-ink a stripe on his forearm, two inches in size, and exposed the skin of his arm to the sunlight for three hours. When the ink was washed away the skin under it appeared unaltered, while the unprotected part was red and swollen, and after several hours showed signs of an erythema, leaving in a few days a pigmentation of the skin. When the experiment was repeated the portion formerly protected became affected, while the pigmented portion of the skin did not suffer. Some diseases of the skin appear to be aggravated by rays of light. Black and Barlow found that small-pox took a mild course and left no scars, even in unvaccinated persons, when the patients were treated in complete darkness. When this precaution was neglected for only a few hours, the disease took its ordinary course and left deep scars. Browne covered one-half of a patient's face with colored gelatin, and on that part no scars were formed. Finsen is of the opinion that only the ultra-violet rays are responsible for the disastrous effect of light on small-pox, and that it is consequently not necessary to keep patients in complete darkness, but red curtains kept closed or red window-panes may be used in the patient's room.—*Hospitals idende—Universal Medical Journal*,, December, 1893.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M. A., M. B., C. M., Professor of Clinical Medicine, University of California, San Francisco.

The Cardiac Tonics in Pneumonia.—LAZZARO draws attention to the successful use of digitalis in cases of pneumonia, first by Traube, and some years later by Petresen, who obtained good results in 755 cases of the disease, employing from 5 to 8 gms. of the leaves daily in the form of infusion. In Italy, Maragliano has also spoken highly of a similar mode of treatment. The author believes that the drug acts by reinforcing the systole of the heart, and so enabling it to surmount the circulatory obstacle set up by the congested lung, and thus to do away with the edema. In order to confirm this view he has tried two substitutes for digitalis in similar conditions, strophanthus and adonis, both of which have a more prompt action and are better tolerated than digitalis. He describes the results in two typical cases, in one of which, a woman of 63, $1\frac{1}{2}$ gms. of the tincture of strophanthus were given daily, and in the other 6 gms. of adonis in the form of infusion. In both cases the disease was brought to a successful issue in three or four days. Lazzaro considers that his results confirm the truth of his idea as to the action of the drug, but holds that it is inadvisable to employ either digitalis or the other cardiac tonics as a routine practice in pneumonia; their use should be reserved for cases in which the heart is compromised.—*British Medical Journal*, September 16, 1893.

Strychnine Injections in Paralysis.—BOLTENOTERN reports the cure of a case of alcoholic paralysis by the above method. There was paralysis of the lower limbs, loss of power in the upper limbs, rheumatoid pains, edema, enlarged liver, albuminuria, and diminished amount of urine. After a few weeks' treatment directed to the latter conditions, only the paralysis remained, and for the relief of this daily injections of nitrate of strychnine were given, commencing with $\frac{1}{70}$ grains, and toward the end using as much as $\frac{1}{7}$ grains, at each injection. In addition to this, the patient had warm baths, with cold irrigations and general faradization once in two days. Four weeks of treatment enabled the patient to feed himself, and to raise himself in bed without aid, and with no discomfort. After another month slight attempts at walking could be made, and after two further weeks the patient was able to raise himself and walk without aid or support. Four mouths after the commencement of this treatment the patient was able to return to his occupation. During the early treatment slight collapse occurred twice, but improved with citrate of caffeine. Injections were made on 32 days, and the total amount of strychnine used was $2\frac{1}{7}$ grains.—*British Medical Journal*, September 16, 1893.

Papain.—SITTMANN has made numerous experiments with papain, and found that $\frac{2}{3}$ of a grain sufficed to change 150 grains of coagulated white of egg mixed with hot water into an opalescent milky fluid in the course of two hours, no free albumin remaining. The action is the same in an alkaline or slightly acid solution. It was used, clinically, in doses of 4 to 8 grains, made into a thin paste, and taken immediately after every meal. Two or three doses served to cause cessation of pain in acute gastritis, and after a further period of 24 hours the appetite returned, a cure being effected in three days. In chronic cases the treatment was more prolonged, but in all of them, including patients suffering from carcinoma, dilatation, and ulcerations great benefit was derived. There was only transient success in gastric neuroses.—*British Medical Journal.*

MEDICINE AND PATHOLOGY.

By Albert Abrams, M. D., Professor of Pathology, Cooper Medical College, San Francisco.

The Etiology of Chronic Heart Affections.—Th. Schott (*Berlin. klin. Woch.*), has prepared a table comprising 750 patients who came under his observation, 245 suffering from organic endocardial disease, and 505 affected with neuro-muscular conditions of the heart. Heredity appeared an important etiological factor, 212 patients stating that relatives were similarly afflicted; and among 245 patients with valvular disease, the same affection was recorded; 58 times among relations in the direct ascending or descending line. The coincidence in families the author attributes not so much to a rheumatic tendency as to the heart being a *locus minoris resistentiæ*, readily affected by severe maladies; and among hereditary causes he also enumerates obesity, arthritis, and arterio-sclerosis. In the 245 cases of valvular disease rheumatism was the cause in more than half the patients, the other factors being in order of frequency; arterio-sclerosis, scarlatina, typhoid, arthritic processes, influenza, diphtheria, measles, etc.; and in one case there could be no doubt as to gonorrheal rheumatism producing valvular disease. The remaining causes were contributed by syphilis, diabetes, icterus and Graves' disease, and kypho-scelrosis. The latter was associated with a systolic murmur in 9 cases. The causes of neuro-muscular disease were dependent on disease of the myocardium (fatty degeneration and myocarditis), or a disturbance of the nervous mechanism of the heart. The latter was produced by mental or physical exertion, abuse of alcohol, tea, coffee, and tobacco.—*British Medical Journal.*

The Regimen of Diabetics.—Professor Ebstein refers to the danger of producing coma in diabetics by changing the diet too rapidly. According to this observer, even when the diabetic symptoms are most favorably influenced by a strict regimen, he fears that a total suppression of an amylaceous diet will often result in coma. This accident is indicated by the presence in the urine of acetic acid as determined with a solution of chloride of iron. Ebstein observes the following rule absolutely: If the urine of a diabetic patient gives an intense red coloration with a solution of perchloride of iron, that is to say, if large quantities of acetic acid are present, amylaceous food is not entirely suppressed, but is allowed to be ingested in small quantities with circumspection.—*Journal de Médicine de Paris*, October 8, 1893.

Endocarditis of Gonorrheal Origin.—M. Leyden presented to the Medical Society of Berlin the heart of an individual who, after an attack of blenorrhagia, suffered from an attack of infectious endocarditis, with signs of aortic insufficiency. In the valvular lesions of the heart Leyden found the characteristic gonococci. He considered this a veritable case of gonorrheal endocarditis, and not a secondary endocarditis produced by the staphylococci or streptococci. In the discussion following, opinion was divided. One of the members announced that the gonococcus was not characteristic of gonorrhea, as it was found in the urethræ of the new born, the parents of whom were absolutely healthy.—*Union Médicale.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M. D., Assistant Physician, State Asylum for Insane, Stockton. Cal.

Amok and Sakit-hati Among the Malays.—DR. W. GILMORE ELLIS, superintendent of the government asylum at Singapore, has published an article telling of certain abnormal conditions of mind among the Malays. The meaning of amok is a furious assault; from this word the English term "to ran amuck" is derived. A Malay who runs amok, runs armed through the most crowded street or village, stabbing right and left at man, woman, or child, relation, friend, or stranger. Many exciting causes of this homicidal passion have been observed: domestic troubles, grief at the death of a near relative, sight of blood, brooding over real or imaginary wrongs, fear of death (as in a foundering ship), shame and disgrace (such as being considered a coward or being imprisoned), and especially malarial fever. Amok is considered by the Malays a kind of suicide. A man, from some cause or other, considers life not worth living and wishes to die; suicide being a most heinous sin according to the Mahommedan religion, he amoks in the hope of being killed. The writer considers amok a form of impulsive insanity, a paroxysm of acute mania allied to post-epileptic moria. The patient has no remembrance whatever of any act of violence. Another peculiar condition of mind which the Malay is subject to in greater or less degree, is called "sakit-hati." The literal meaning of this term is heart-sickness. The sufferer sits down and broods over his wrongs, or supposed wrongs, with revengeful feelings, and is altogether filled with the pain of grief. They do not appear to be really insane, and as a rule, quickly recover; but sometimes it has been found necessary to send them to an asylum. They remain in the condition described for periods varying from a few hours to a few weeks, but rarely longer than four or five days. At the time of the attack their mental activity seems to be impaired and the memory is also slightly affected. If it were possible to get information as to the patient's condition shortly before the outbreak, Dr. Ellis thinks there would always be found some divergence from the man's usual habits, and in some cases marked peculiarities. Malays say that the man who runs amok always suffers from sakit-hati first.—*Journal Mental Medicine.*—*Journal Nervous and Mental Disease*, October, 1893. [If the last statement of the Malays be true, the two abnormal mental conditions above described would resemble the picture of a complete attack of *folie circulaire;* the only difference being that in the first or melancholy stage, the grief is mixed with revengeful feelings.—A. W. H.]

FORMULÆ.

By GEO. B. SOMERS, M. D., San Francisco, Cal.

Pleurisy.—EKLUND covers the chest with thick layers of cotton-wool, and applies chloroform liniment to relieve pain. Internally he uses:

Morphine hydrochlorate	gr. iss
Pulverized camphor	gr. xv
Quinine sulphate	ʒ ss

To be divided into 20 pills.

S.—Two or three times a day,

As an alternative he sometimes uses:

Sodium salicylate Extract of licorice	āā ʒ iiss
Distilled water	℥ x

S.—One tablespoonful five times a day.—*Universal Medical Journal.*

Otalgia:

Menthol	℈i
Camphor	℈i
Liquid vaseline	℥i

Instil into the ear several times a day.—*Medical Press and Circular.*

Chronic Constipation:

Aloinæ	gr. iv
Strych. sulph.	gr. ¼
Ext. belladonnæ	gr. iss
Pulv. ipecac.	gr. vi

Mix and divide into 12 pills.

S.—One nightly.—*Medical Record.*

Bromoform in Whooping Cough.—Much testimony is given in regard to the efficacy of this drug in pertussis. EARLE'S formula is:

Bromoformi	gtt viii
Tr. opii camph.	ʒi
Syr. acaciæ	ʒiv
Aq. anisi	
Aq. laurocerasi āā *ad*	℥i

Shake well.

S.—Half to one teaspoonful four times a day to a child one year old.—*Times and Register.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for November.—The deaths registered in 92 town districts of the State, during the month of November, in a population of 808,049, correspond to an annual rate of 14.76 a thousand, the total mortality having been 1,098. 87 deaths were due to zymotic diseases, giving an annual rate of 1.28 a thousand. Of these 13 were due to diphtheria, 15 to cholera infantum, 30 to typhoid fever, 10 to diarrhea and dysentery, 1 to cerebro-spinal fever, 7 to whooping cough, 3 to croup, 6 to intermittent and remittent fevers, 1 to scarlet fever, 1 to measles, and 0 to small-pox. 334 deaths resulted from diseases of the respiratory organs, giving an annual rate of 4.92 a thousand. Of these, 169 were due to consumption, 105 to pneumonia, 49 to bronchitis, and 11 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.50 and 1.54, respectively. 80 deaths resulted from diseases of the heart, 9 from alcoholism, 2 from erysipelas, 28 from cancer, and 466 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 578,500, was 17.16. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from San Diego.

METEOROLOGY.

Summary for November.—*Temperature.*—The normal temperature for the State for November is 53.4°, the mean for November 1893, was 53.2°; a departure from the normal of -0.2°. The highest monthly mean was 71°, at Salton, in the desert regions of San Diego county, 263 feet below sea level; the lowest, 35° at Summit, in the mountain regions of Placer county, 7,017 feet above sea level. The maximum was 93°, at Salton on the 8th; the minimum, 10°, at Boca, (5,531 feet above sea level,) on the 19th. The greatest monthly range was 65°, at Boca; the least, 21°, at Mokelumne Hill, 1,550 feet above sea level.

Precipitation.—The normal precipitation for the State for November is 2.43 inches; the average for November was 2.56 inches, a departure from the normal of +0.13 inches. The greatest monthly precipitation was 15.07 inches, at Fort Ross; the least, a trace, at Barstow and Nordhoff.

Wind.—The prevailing direction of wind was westerly.

Unusual Features.—There were no unusual phenomena during the month.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for November, 1893.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn.........Cal.	57.0	78.0	39.0	------	------	------	----	5.32	------	----	----	----	S.E.	Southern Pacific Company.
Berkeley......... "	52.0	70.0	42.0	60.0	49.0	11.0	10	5.22	84.0	13	4	13	S.	Obs. University of California.
Colfax........... "	50.0	82.0	32.0	------	------	------	----	7.32	------	----	----	----	S.E.	Southern Pacific Company.
Eureka........... "	51.0	66.0	34.0	57.0	45.0	12.0	14	9.87	94.0	11	5	14	S.	Weather Bureau Dept. Agr.
Fresno........... "	53.0	74.0	29.0	66.0	40.0	26.0	2	0.16	58.0	17	10	3	N.W.	" " "
Keeler........... "	49.0	73.0	24.0	59.0	38.0	21.0	3	0.12	38.0	23	6	1	N.E.	" " "
Los Angeles.... "	57.0	86.0	39.0	69.0	46.0	23.0	4	0.20	74.0	12	15	3	W.	" " "
Monterey....... "	55.0	76.0	28.0	------	------	------	----	0.00	------	----	----	----	S.W.	Southern Pacific Company.
Napa........... "	54.0	74.0	36.0	63.0	46.0	17.0	8	4.03	74.0	11	9	10	S.	Station Napa Insane Asylum.
Oakland......... "	54.0	70.0	38.0	60.0	48.0	12.0	12	5.76	97.0	14	3	13	W.	Chabot Observatory.
Paso Robles.... "	43.0	70.0	20.0	------	------	------	0	0.00	------	----	----	----	N.	Southern Pacific Company.
Red Bluff....... "	53.0	79.0	32.0	63.0	44.0	19.0	10	4.22	65.0	17	3	10	N.W.	Weather Bureau Dept. Agr.
Sacramento.... "	54.0	72.0	32.0	64.0	43.0	21.0	7	2.92	66.0	13	6	11	S.	" " "
San Bernardino "	54.0	78.0	34.0	67.0	41.0	26.0	1	0.30	68.0	21	4	5	W.	A. K. Johnson, M. D
San Diego....... "	58.0	83.0	40.0	66.0	50.0	16.0	3	0.91	74.0	18	11	1	W.	Weather Bureau Dept. Agr.
San Francisco.. "	56.0	74.0	44.0	61.0	50.0	11.0	13	4.18	82.0	11	7	12	W.	" " "
Santa Barbara.. "	57.0	82.0	40.0	67.0	48.0	19.0	2	0.07	69.0	21	4	5	W.	Hugh D. Vail.
Santa Cruz...... "	56.0	79.0	34.0	68.0	44.0	24.0	4	4.40	------	19	7	4	S.W.	W. R. Springer.
Yuma..........A. T.	60.0	86.0	32.0	75.0	45.8	30.0	1	0.19	52.0	23	6	1	N.E.	Weather Bureau Dept. Agr.

T. means a trace of rain. Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: JANUARY, 1894.

THE COMMENCEMENTS.

The commencement exercises of Cooper Medical College were held in the auditorium of the college building on Thursday evening, December 7, 1893, before an audience that more than filled the large hall. After an overture by the Hungarian Orchestra, which furnished the music for the occasion, and prayer by the REV. W. A. GARDNER, the degrees were conferred by the President of the College, DR. L. C. LANE. This was the largest class that has ever left the institution. The valedictory address on behalf of the Faculty was delivered by DR. G. F. HANSON, in a most acceptable manner. The second address was made by FRANK J. SYMMES, ESQ., but unfortunately could not be heard by those in the back part of the hall. The benediction was pronounced by REV. MR. GARDNER, and the audience dispersed, while the orchestra rendered a number of familiar college songs.

The following are the names of the graduates: Benjamin Apple, John Sheridan Barrett, B. A.; Benjamin Charles Bentley, Ph. B.; Thomas P. Bodkin, Lawrence Boido, B. S.; Charles Foster Burgess, George Washington Burk, James Crounse Campbell, Stephen Patrick Cavanagh, James Wesley Clark, Angus Bertram Cowan, Thomas Edward Cunnane, Frank Xavier Emerson, William Ferdinand Friedhofer, Harry Sherman Gossage, Graily Hewitt Hall, Carl Christian Hansen, James Lonas Hardin, Herbert Wallace Hatch, George Henry Heald, Andrew Mitchell Henderson, A. B.. Edward Ferris Holbrook, Leonard Charles Hull, John Morris Kane, Alfred Galton Kelleher, Donald Clayton Lazier, Edward Giles McConnell, John Augustus McNear, Jr., Henry Meyer, Harry Orson Miller, John McIntyre Morrison, Milton Ashby Nelms, Ralph Thompson Orvis, Alexander Patterson, Mark Lytton Pettit, Henry James Charles Antone Sartori, John Goodwin Steiner, M. A.; Walter Martin Thorne, Katherine Van Harlingen, Agnes Walker, Moses Wylie Ward, B. S.; Maude Amanda Waterhouse.

The total number of students in attendance during the past session was 228, the number of matriculates being 176.

The graduating exercises of the Medical Department of the University of California were held in Odd Fellows' Hall, San Francisco, on Tuesday evening, December 14, 1893. The students of the College assembled in the lodge room of the hall, and at half-past eight o'clock marched in, headed by the Medical Faculty and the President of the University, PROFESSOR MARTIN KELLOGG. The faculty and the graduating class wore the scholastic cap and gown, while the remainder of the student body were decorated with the blue and gold ribbons of the University. After an overture by Brandt's orchestra, the exercises were opened with prayer by the REV. WILLIAM HALL MORELAND, M.A. The address on behalf of the Faculty by PROF. JOHN W. ROBERTSON, was apparently as interesting to the general audience as to the students, judging from the enthusiastic applause with which it was received. The degrees were conferred by PROF. MARTIN KELLOGG, President of the University, who spoke in Latin, which added solemnity to the occasion.

PROF. R. BEVERLY COLE, President of the Faculty, delivered a short address, in which he announced that the requirements for admission to the Medical Department had been raised to the same standard as those for admission to the Academic Colleges; that a knowledge of Latin would be required of future matriculates, and that the course would be extended to four years. PROFESSOR COLE then administered the Hippocratic oath to the graduates, in a most impressive manner, each member of the class ascending to the platform and signing his name, amid the applause of friends and of the undergraduates.

The REV. WILLIAM HALL MORELAND gave the benediction, after which the students collected in the lobbies and indulged in college songs. Later in the evening the Faculty gave a banquet to the graduates.

The following are the names of the graduates: John William Aird, Richard M. H. Berndt, Rawlings Cadwallader, M.A.; David Andrew Conrad, Abraham Lincoln Cothran, Millicent Elizabeth Falck, Bartholomew Francis Fleming, Frederick Charles Flesher, Ernest Maynard Freeman, B.A.; Alexander Marshall Gali, Cosmos Andnew Glover, Edward Shelton Horton, Clarence Halleck Hulse, Hugh Lagan, Charles Sylvester Maguire, B.S.; Charles Francis McCarty, Henry du Rest Phelan, Gardner Perry Pond, Stephen Hester Rantz, W. Kelly Sanborn, Ph. G.; Sydney Henry Schrader, Grace Simon.

The total number of students in attendance during the past session was 113, the number of matriculates being 55.

The Commencement Exercises of the California College of Pharmacy took place in Odd-Fellows' Hall, San Francisco, on Tuesday evening, Nov. 28th. The hall was tastefully decorated with blue and gold, the University colors, and every seat was filled.

After some introductory remarks by MR. F. A. BECKETT, Chairman of the Board of Trustees, the address of the evening was to have been delivered by the HON. W. S. BARNES. He, however, was unfortunately confined to his house with *la grippe*, so W. M. SEARBY, the Dean, in a short speech, encouraged the audience to accept their disappointment with a good grace, and then gave some points in connection with the College, and the work most unselfishly done by its Board of Trustees. He pointed out the fact that three of the faculty and all of the Instructors, as well as five out of the seven members of the Board of Trustees, were Alumni of the College, evidencing at once the good work done by the College, and the *esprit du corps* of the Alumni.

The degrees were conferred by President MARTIN KELLOGG; the valedictory on behalf of the Faculty was delivered by PROFESSOR FRANK T. GREEN; that on behalf of the Graduates by J. A. McNAMARA, The gold medal was awarded to JOSEPH W. SCAMELL, and the second prize to HAROLD VON DER LEITH.

The following are the names of the graduates: Walter Wadsworth Ayers, Hubert Francis Bagley, Edward Robert Lee Bare, Kenneth Burton Bowerman, George Watson Burnett, Clarence Arthur Chapman, Francis Joseph Donnelly, Joseph Henry Drössel, George Woodward Dufficy, Oscar HermannFolkers, George Anthony Green, Walter Marshall Hedrick, Charles Porter Hirst, William Peter Johnson, Harold von der Leith, Carl Louis Mendel, William Belknap McKenny, Samuel Miller McKenny, John Alexander McNamara, Scollay Parker, M.D.; George Ichabod Ross, Joseph William Scamell, Louis Henry Scherb, Harry Spiro, Ike Tobriner, William Augustus Upp, Rudolph Fred Vogel, Samuel Leroy Waller, Eugene Carlisle Whiting, Matthew Sylvester Wise.

The total number of students in attendance during the past session was 95, the number of matriculates being 51.

NOTES.

Dr. A. Abrams.

Dr. Albert Abrams has been appointed Professor of Pathology at Cooper Medical College, a position that he will certainly fill with entire satisfaction to all concerned.

A New Medical Register and Directory Supplement.

The Board of Examiners has announced that it will publish a supplement to the sixth edition of the Medical Register. This will consist of the new names in the same form as the general list. The county lists will be revised, corrections being made in the old names and the new ones added. There will be no change in the old general list.

Mathew's Medical Quarterly.

Dr. Joseph M. Mathews, of Louisville, Ky., proposes to issue a new quarterly to be devoted to diseases of the rectum and gastro-intestinal diseases, rectal and gastro-intestinal surgery. Dr. Mathews has, for many years, given these subjects special attention and will certainly be fully qualified to make an interesting and valuable periodical. The journal will appear on the first day of April, July, October, and January.

Dr. J. F. Morse.

Owing to the pressure of his many engagements and the demands of a large and increasing practice, Dr. Morse has been compelled to resign his position as an active collaborator in the department of surgery with which he has been connected for several years. Dr. Morse's reputation as a clinical teacher has long been an enviable one, and it is to be regretted that increased professional cares must interfere with active literary work.

The Medical Sentinel.

The *Pacific Medical Record*, of Portland, Or., has changed its name to *Medical Sentinel*, in order to avoid conflicting with journals that have been already established. The management, editorial and business, will remain the same. This change is certainly desirable as tending to distinctly identify the journal. Our contemporary, however, when many years older, will realize that such a little matter as this will not stand in the way of careless or piratical exchanges.

American Medical Publishers' Association.

The first annual meeting of this Association was held in the Grand Hotel, Cincinnati, on Monday, December 4, 1893, and steps were taken in the direction of active routine work. The by-laws and rules were revised and amended, while the name was modified in accordance with a demand from medical publishers of a general nature who desired to become members of the Association. The active coöperation of every medical publisher is earnestly solicited. The next meeting will be held in Washington, D. C., September, 1894. The following officers were elected for the ensuing year: President, Dr. Landon B. Edwards, Richmond, Virginia; Vice-President, Dr. J. C. Culbertson, Cincinnati, Ohio; Treasurer, J. MacDonald, Jr., New York City; Secretary, Charles Wood Fassett, St. Joseph, Mo.

The Journal of the American Medical Association.

An editorial in a recent issue of *The Journal* strongly urges the profession to, in every way, increase the membership, and therefore the influence of the Association. The writer says: "Let every member use his personal influence to induce every worthy physician of his acquaintance to become a member of the Association, or a subscriber to *The Journal*. His duty to the Association will then have been accomplished. Let us have no stopping place until our membership surpasses any other. Are there wrongs in the Association? Correct them by appearing in your place when the Association meets, or write your views to your *Journal* for publication. In our Association the majority govern; if your views are correct, you can always have an intelligent support in the Association. Help your *Journal* property, of which you are part owner, by giving it all the influence you can wield in its favor. To ask a man to help build up his own property is surely not asking him too much." The article concludes by stating that if each one did his full duty in the matter the great work of organization would be accomplished in two years.

A Secretary of Public Health.

Dr. U. O. B. Wingate, of Milwaukee, Chairman of the Committee of the American Medical Association on a Department of Public Health, in discussing the proposed bill of the New York Academy of Medicine, says:

"It is generally acceded by physicians and sanitarians who have given the matter careful thought, and are not prejudiced, including members of the New York Academy of Medicine, that the bill to provide for a Secretary of Public Health in the Cabinet of the President, which was prepared by the American Medical Association, is the only ideal scheme thus far presented to settle the sanitary problem so far as national legislation is concerned. All other bills are make-shifts, and make-shift legislation is pernicious legislation, as is abundantly shown in the history of our own country. The bill proposed by the New York Academy of Medicine is not claimed by its advocates to be the best solution of the problem, and is cumbersome, expensive, and impracticable. Any legislation asked for or favored by the medical profession which is not designed for the highest good, conceived in the light of the most advanced scientific knowledge, is derogatory to the best interests of the medical profession, and as a result detrimental to the best interests of the people and country. No lesser office than one on a parity with the members of the President's Cabinet is consistent with the dignity of maintaining sanitary relations with other nations, with the rank of the medical profession, and with the importance of best protecting life and preserving happiness in our own nation. That if this object cannot be obtained at present it is unwisdom to favor legislation which, by reason of its imperfection, will belittle the medical profession, retard the progress of sanitation and medical science, and reflect discredit upon all who espouse it."

AMERICAN MEDICAL ASSOCIATION.

Membership in the American Medical Association.—"This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues and subscription for the *Journal*. Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly *Journal* of the Association will be forwarded regularly."

The "American Lancet," speaking of the coming meeting of the Association, says: "Our California friends are 'hustling,' and have been since the Milwaukee meeting. They are stirring up the entire profession west of the Rockies by all possible means. They are instructing them respecting the Association, and seeking to secure their coöperation with it. Every indication points to a larger meeting of the medical profession than has ever met in this country before. Preparations are being made for the profit, comfort, and pleasure of all visiting members from east of the Rockies. Those who can and do not provide for attendance upon this meeting will make a mistake. Section activity has already begun by the most 'live' among the officers of the sections. Others will soon wake up, and hundreds will be laboring to prepare some work of value to present at one or more of the sections of our National Medical Association." Dr. Leartus Connor, the editor of the *American Lancet*, was a hearty supporter and earnest friend of California at the Milwaukee meeting, and his excellent speech in favor of San Francisco materially assisting in molding the sentiments of members in that convention.

Application Blanks for Membership.—On advertising page v we print a convenient form of application blank that is being circulated by the Association *Journal*. Any physician desirous of joining the Association can cut out this blank, and, having properly filled it, can mail same with his subscription to the Treasurer. As many physicians seem to be waiting for these blanks before joining the Association, it is pertinent to remark that the blank is not a necessity but merely a convenience. The essential is a certificate signed by the President and Secretary of a State or local Medical Society, and this, accompanied by $5, will be duly honored by the Treasurer. Dr. Kerr, the Secretary of the Medical Society of the State of California, has announced that the circulars of his Committee of Arrangements will on this occasion be mailed to every physician in the State, and will be accompanied by blank applications for membership in the Association. Meanwhile our readers will find each month the regular application form in our advertising columns, and we shall be at all times ready to afford any information in these matters.

SOCIETY PROCEEDINGS.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, December 12, 1893.

Vice-President H. E. SANDERSON, M.D., in the chair.

New Member.—J. T. JOHNSON, M.D., was duly elected a member of the Society.

Notes on La Grippe Following Childbirth.—DR. J. HENRY BARBAT read a paper on this subject. The first case reported was that of a primipara aged 17 years, delivered September 7, 1893, of a healthy child. The placenta was removed by Credé's method. There was a laceration of the perineum, but this was at once repaired by silkworm gut sutures. Within two hours after delivery patient complained of pains all over the body, slight chilliness, and the temperature was found to be 101° F. Twenty-four hours later the temperature was 104°, accompanied by slight delirium, and still considerable pain all over the body. There was no abdominal tenderness on deep pressure, lochia clean, no odor, no uterine tenderness. The uterus was curetted with the dull wire curette and found to be perfectly clean; it was then irrigated with a solution of hydronaphthol. This was followed by a severe chill, and the temperature rose to 105° F. Patient had low muttering delirium, tongue glazed and cracked, sordes on teeth, and general appearance of approaching dissolution. Dr. C. E. Farnum was called in consultation, but could see nothing that would indicate the condition as the result of confinement. He thought it might be some form of ptomaine poisoning and recommended stimulation. Full doses of quinine and whiskey finally brought patient around, but she was very weak for a month afterward. At no time were the lochia suppressed or offensive, nor was there any uterine or abdominal tenderness. Sutures removed on fifteenth day with perfect union. Previous to this the speaker had had no case of *la grippe* this season, but subsequently had a number of cases of influenza.

About a month after, a second case occurred, the patient being attacked ten days after delivery. On the tenth day patient said she did not feel well, but complained of no definite symptoms. The same afternoon there were severe pains all over the body, but worse in back and head. Temperature 102° F.; face flushed; conjunctivæ injected, and slight cough. As patient up to tenth day had progressed favorably, I diagnosed *la grippe*, and gave 10 gr. doses of antikamnia every three hours, with liberal doses of whiskey. In two days patient was able to be out of bed, but weak. The third case occurred a week later, symptoms appearing on the third day after confinement. This alarmed me, as the nurse was careless and uncleanly, and I feared septic infection. The symptoms, however, seemed so plain that I diagnosed "grip." Patient had burning diarrhea and irritable rectum, which opium and belladonna suppositories relieved. The maximum temperature was 101° F. There was considerable cough after the fifth day. Antikamnia and whiskey enabled patient to be out on the tenth day, though weak. The fourth case followed a week later, the first symptoms occurring two days after delivery of a seven months' fetus; the placenta being removed by the hand introduced into the uterus. The characteristic pains in the back, injected conjunctivæ, and negative abdominal symptoms soon cleared up the diagnosis. The same treatment was employed as in the other cases, and gave equally good results. In this case the premature delivery may have been due to the attack of "grip." There has been very little literature the past year on this subject; the only thing I find being a paper by Dr. Addinsell, read at a recent meeting of the Obstetric Society of London, in which he shows how the symptoms of influenza differ from those of puerperal septicemia. He says influenza attacks the weakest spot, and quotes several cases attacked during menstruation that continued to suffer from ovaritis. He also suggests that the nervous symptoms seen in puerperal septicemia might be due to necrotic elements of the endometrium.

DR. C. DEWITT said that he had seen a similar case on November 5th. The lochia were increased, but not offensive.

DR. G. W. DAVIS said he would be alarmed about the first case, whether or not it were of septic origin. The other cases seemed clearly to have been influenza.

DR. W. F. CHENEY said influenza was undoubtedly an infectious disease, though no bacillus had as yet been discovered. He thought there was no doubt as to the diagnosis in these cases, though septicemia could give rise to all the symptoms that had been mentioned by Dr. Barbat. Curetting was certainly dangerous.

DR. C. G. KENYON thought an important diagnostic symptom was the peculiarly light, furred tongue, present in perhaps all cases. Whiskey was good treatment, but, for fear of establishing a habit afterward, he was disposed to prescribe it rarely.

DR. G. W. DAYWALT reported a case of *la grippe*, following confinement on the third day. That evening patient was restless and nervous, and the temperature rose to 104° and to 104.5° at 10 P. M. Two intrauterine douches were given during the evening, and at midnight there was a severe chill. Fifteen grains of phenacetin and quinine were given every four hours, and the following morning the temperature had fallen to 101°. At noon it rose to 104°; next day it fell, and had remained so afterward.

DR. C. E. FARNUM did not think that curetting was objectionable in Dr. Barbat's first case. Irrigation often fails, and he had never had unfavorable results from the use of the curette after confinement. Antikamnia and alcohol relieve pains most promptly. Whiskey given thus during acute attacks does not create a habit. He thought that in the first case that had been reported the persistence of the symptoms after curettage and irrigation pointed to *la grippe*.

DR. C. G. LEVISON said that streptococci were not found in the first case, yet he could not be positive of the diagnosis though all the symptoms resembled *la grippe*.

DR. M. KROTOSZYNER said that in these cases the diagnosis was not easy. The symptoms of *la grippe* were not yet complete, and they should be made more definite.

DR. C. G. KUHLMAN did not regard *la grippe* as a scientific term. Cerebrospinal neurosis was preferable. Some women exhibited *post-partum* phenomena, often of an infectious character, and these cases may have been included in this category.

DR. BARBAT, in replying, said he regarded whiskey as *the* remedy in *la grippe*. He believed that experimentation had already proved the bacteriological origin of the disease. In reply to an inquiry, he said one of the cases reported resided in a neighborhood where *la grippe* was very prevalent.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, November 18, 1893.

The President, LUKE ROBINSON, M D., in the Chair.

Thyroidectomy.—DR. DUDLEY TAIT exhibited a man from whom he had removed an enlarged thyroid gland. He said: This case possesses much interest from a diagnostical and surgical point of view. The history was of a 12 years' growth, quite large, extending from the hyoid to the sternum, overlapping the latter about 1½ inches. The larynx was displaced to the left. On palpation the mass was hard and dense, but gave more resistance than would be expected if fluid were contained in it; the presence of fluid was demonstrated, however, by an exploratory puncture. The respiration was impeded, both during effort and rest; the voice was also affected. Enucleation was proposed and accepted. On exposing the mass, I was surprised to find simple hypertrophy with extensive dilatation of the blood vessels. The mass was too large to permit of ligation of the inferior thyroids, so the larger vessels were ligated as the operation proceeded. Recovery was uneventful except that on two different occasions, having used silk to ligate the larger vessels, pus formed and had to be removed. At one time quite a quantity collected to the right and left of the thyroid above the sternum. Under cocaine this was opened, carefully curettted, and a silk ligature found.

Primary Sore of Lip Simulating Herpes.—DR. D. W. MONTGOMERY exhibited a woman, with a specific infectious sore on her lower lip. The case was at first taken for herpes. He remarked: Herpes as a primary lesion on the lip is rare, whereas at usual sites it is not rare. If we have confidence in the history, this would seem to have developed after herpes, but the patient now has a marked roseola. This is a specific lesion, a round-celled infiltration; it varies in extent and density, there being no induration now or before in this case. Induration, when present, is a good diagnostic point; when absent, it does not amount to anything. Sometimes the whole lower lip becomes much enlarged, and usually with marked induration. It is curious how small the resulting scar is; this is due, no doubt, to the fact that the ulceration is at the expense of the neoplasm, not the real tissue of the lip, and when the neoplasm disappears the tissues look normal. Dr. Tait, some time ago, sent a patient to me with an ulcer of the cheek, very deep, with high edges. Elevated ulcers on the cheek come out like sarcomas with depressions on the apex. Dr. Tait's case was similar, only more depressed on the apex. As a rule, these ulcers are very stubborn. I applied the acid nitrate of mercury, and the ulcer quickly disappeared. Hutchinson speaks very highly of this acid, and I cannot see why it is not more used; it is an extremely useful caustic. A day or two ago the patient was seen and hardly any scar was visible, not nearly what one would expect from the extent of the ulcer. Taylor says elevated ulcers come from chancroidal erosions. Kaposi says that if the edges indurate down into the tissues, it may form a Hunterian chancre. In the herpetiform there is simply a raising up of the horny layer by the serum, as there is more serum effused than round cells.

DR. G. F. SHIELS: Does Dr. Montgomery mean to say that the induration is of no value? Is not the excess of induration in the lip due to the constant motion there?

DR. MONTGOMERY: If induration is present, it is of value as one point; if absent, the absence is of no value. The excess of induration in the lip is said by some to be due to the way the blood vessels run. Take, for instance, the Hunterian chancre; it generally is found in the sulcus coronæ, as there the blood vessels dip downward into the corpus cavernosæ.

Hysterectomy for Epithelioma.—DR. H. KREUTZMAN exhibited a uterus taken from a woman aged 40, who had consulted him at the Polyclinic. She complained of pelvic pains. On examination, found an extremely small uterus, with a small tumor extending from the external os. Four weeks ago, under ether, he had split up the cervix to the vaginal walls, and thought the tumor was a fibroid. A piece was removed and on examination Dr. Grazer found suspicious tissue, which was confirmed by Dr. Montgomery. At the second operation the tumor was found much enlarged since the first operation. The abdomen was opened and ovaries and uterus removed; an ovarian cyst was found in connection with the epithelioma. Epitheliomas and other tumors together are not rare in the female genital organs. One case occurred at the German Hospital some little time ago. A piece of the cervix was excised and an epithelioma diagnosed by Dr. Montgomery. Eighteen days afterward he attempted to remove the uterus by the vagina; there were extensive adhesions between bowel and uterus from the former operation. He saw that it would be necessary to open the abdomen from above, and did so, and finally removed the uterus.

DR. G. F. SHIELS read a paper on "Cholecystotomy followed by Cholecystoenterostomy" [published at p. 23], and demonstrated the use of Murphy's button, or rather, Barbat's modification of it, which he claimed was superior to the original. The speaker said the button was perfectly useless in lateral intestinal anastomosis, as there was a resulting cicatrization of 75 per cent., which left the opening far too small.

Dr. G. L. Fitch said: I simply wish to speak of the good results one gets in operations on Chinese. Almost any surgical operation can be performed with impunity, with hardly any shock. I believe this is due to the fact that they are vegetable feeders and live very plainly. When in Santa Cruz, I saw a Chinese who had been run-over by a street car. I found it necessary to amputate his left leg at the knee and the right leg lower down. He managed to get hold of a bottle of brandy 48 hours after and got drunk, inserted his fingers in the knee flaps, tore them open, and thumped the other leg on the floor till it was torn open. Both wounds finally healed all right. In the operation reported by Dr. Shiels, I passed a flexible probe into the duct more than six inches, but nothing but a soft, doughy mass could be felt. At the autopsy, I found a clean, smooth hole, resulting from the use of the button, and extensive thickening of the gall bladder, which was nearly half an inch thick.

Dr. Stanley Stillman: Regarding the Chinese standing operations, well, I believe they do. I have had some experience in dispensary practice with them. In one case I removed the entire lower jaw in two operations at the Cooper College Dispensary. The Chinaman walked down to Chinatown after the operation, and has recovered. He can eat rice, etc., and does not seem to miss the jaw at all.

Dr. Geo. Childs Macdonald: I believe that the lower in the scale of humanity we go we can operate with more impunity. On the aborigines of Australia we can do almost anything. I remember one case where a blackman was caught in a trap, and chopped his foot off to free himself. He was taken to camp and given cigars and whisky. He said they were good, and that for more they could chop off his other leg. Regarding the diagnosis of gall stones, when I was a resident of the Royal Infirmary I saw a case nearly identical with Dr. Shiels', diagnosed as cancer of the head of the pancreas, but it turned out to be a gall stone, and the patient died.

Dr. Dudley Tait: All surgeons and physicians agree as to the difficulties encountered in the differential diagnosis of cancer of the head of the pancreas and chronic obstruction of the common duct by stones. At times the diagnosis is impossible. In the present case, however, the few symptoms mentioned point to the cancerous nature of the affection. The patient's age, 56, the absence of any previous symptoms pointing to cholelithiasis, the hypertrophy of the liver as stated in the measurements given by Dr. Shiels, the absence of intermittent jaundice, the constant and permanent absence of bile in the feces, the absence of fever or signs of infection, the presence of a distended gall bladder, the hemorrhage following incision of the gall bladder, all are indicative of cancer. A more systematic clinical examination would probably have conduced to a more precise diagnosis. In doubtful cases the diagnosis is generally made as soon as the abdomen is opened, a thorough search with the hand being the first and essential step. With a small opening this is always feasible. Such an opportunity was, for unknown reasons, not utilized in the case under discussion, although the abdomen had been opened on two different occasions. Supposing that it were a case of gall stone impacted in the common duct, of what possible service could cholecystotomy be? Of none whatever. There was no indication, no *raison d'etre* for cholecystotomy in Dr. Shiels' case. Moreover, the method of performing this simple operation in two steps is decidedly faulty, and is no longer approved. In septic cases rapid work is evidently indicated, whereas in non-septic cases there can exist no danger in immediate incision. Similar reasons have caused surgeons to abandon gastrostomy in two steps. The thickened walls of the gall bladder referred to by Dr. Fitch are always met with in cases where there has existed for a certain length of time an obstacle to the flow of bile. The unsuccessful attempts at probing are not to be wondered at, for, as Terrier and Dally recently demonstrated, catheterization of the cystic duct is possible in only 30 per cent. of cases. Abbé, of New York, also reports similar results. The distortion mentioned exists in the normal duct, and, with the numerous valves, explains the difficulty of probing. The value of the term "bile starvation" is not substantiated by recent publications. On the contrary, bile is no longer considered essential to life; it is more excrementitious than a digestive secretion. Scores of cases have been reported of patients suffering from chronic obstruction and biliary fistula, who, notwithstanding the entire loss of bile, gained flesh and health. Harley's patient lost 380 grammes of bile daily for over 8 years. Richardson, of Boston, and Abbé, of New York, have both reported analagous examples. I have at present a case under treatment in which 16 days after cholecystotomy the patient had infectious cholangitis, giving rise to complete obliteration of the common duct; all the bile flows through a cutaneous fistula. Notwithstanding this, the patient is gaining daily in strength and flesh. I expect later to run the bile into the intestine, provided it has not resumed its natural course. Cholecystoenterostomy is a simple procedure devoid of danger when properly executed. It has the indorsement of all who have tried it. It was at one time argued that after such an operation infection might occur from intestinal contamination as in analogous cases of uretroenterostomy from the same cause. This assertion has proved groundless. A greater objection is to be found in the ultimate cicatricial stenosis at the opening. Richelot, of Paris, recently reported a case where he had utilized a small incision for an anastomosis between the gall bladder and the duodenum, and in which jaundice recurred some months later, the autopsy showed complete obliteration at the opening. The incision, therefore, should be large, measuring at least 1½ inches according to Abbé. While I agree entirely with Dr. Shiels regarding the uselessness of Murphy's button in intestinal surgery, I differ as to its use in the gall bladder. I am inclined to believe that the opening thus made would prove too small. In using the colon for anastomosis, the dragging of the intestine over the colon can be avoided; the operation is somewhat easier. I believe cholecystoenterostomy will prove of great value in cancerous affections and in cases of cicatricial stenosis of the common duct, but, in the majority of cases of cholelithiasis, the judicious use of the knife, with proper drainage or crushing, will supplant all other operative procedures, In the diagnosis of cholelithiasis one should not forget the infectious element—the role played by the bacterium coli commune. If the stones constitute the primary cause of the clinical manifestations of cholelithiasis, the essence consists in the infectious and ulcerative processes in the biliary passages. Stones may remain in the gall bladder for years and give rise to no pathological changes, hence to no symptoms, In hospitals for the aged, as the Salpetriére, stones are frequently found in 30 to 40 per cent. of autopsies; but if there be added an infectious element, the pathological and clinical manifestations change entirely. The bacterium coli commune causes an exudative inflammation, cholangitis, cholecystitis, hepatitis without suppuration. I fully agree with Dr. Shiels regarding the immunity from shock in Chinese patients: they constitute an excellent soil for surgical work. I find them, however, hypersensitive, and have never been able to perform any operation on them without resorting to cocaine or chloroform.

Dr. Shiels: The immunity of the Chinese to pain and shock is in part attributable to their having no particular form of religion. We know that the mind has a great deal to do with surgical shock, and besides that the Chinese are very stolid. I do not think Dr. Tait could have listened very attentively to my paper. There was no hypertrophy of the liver, the enlargement was due to congestion. As to cancer of the ducts, there was none, it was simply an edematous condition. Regarding the passing of a probe, it is not a difficult matter in the cadaver. In this case we could have passed the finger in. Speaking of two steps in the operation of cholecystotomy, there is no necessity for the two steps; but where there is much jaundice the bleeding is difficult to control, which was demonstrated in this case, we had to use the actual cautery. There was a rapid violent oozing. In regard to the necessity of bile, I think that nearly all agree that it saponifies fat, and aids in digestion. With reference to the contraction of the opening after the use of Murphy's button, it is possible for the bile to pass through a very small opening, and Dr. Tait will agree, I am sure, that Lembert's suture of the gall bladder is much more difficult than the use of the button.

Dr. Tait: Cases of chronic fistula of the gall bladder are not rare. I myself have now a case where a woman is losing all her bile, and still gaining strength.

Dr. J. F. Morse: I want to ask why cholecystotomy is performed at all under any circumstances?

Dr. Shiels: Cholecystotomy is fraught with less danger than cholecystoenterostomy.

Dr. Morse: Cholecystectomy is easy, and another operation will not be required to remove the stones. There are many other reasons besides the time. In stitching to the abdominal walls we must consider the patient; the walls may be thick, the liver may be contracted, or deeply placed in the cavity, and may have to be raised. The anesthetic may cause vomiting, and then there is a liability of tearing loose the stitches, with a subsequent fistulous opening, that will not heal in one out of ten cases. Personally, I have had far better success in cholecystectomy than with cholecystotomy. Langenbeck, of Berlin, I believe, was the first to do the operation. Growths are now removed from the liver itself, as well as the gall bladder. It has been found that pressure on the liver will stop bleeding from its substance.

DR. TAIT: Every case has its separate indications. I do not see any indication for cholecystotomy. One must hesitate before removing a healthy gall bladder, unless to prevent a possible recurrence of gall stones, or if infection sets in.

DR. HARRY M. SHERMAN read a paper, "The Probable Cause of the Limp of the First and Second Stages of Hip-joint Disease." [Dr. Sherman's paper was read by title at the Pan-American Medical Congress, and will appear in the proceedings of that organization.] He also presented the following letter from OTTO VON GELDERN, C. E., discussing the special mechanical questions in the femur, hip-joint, and pelvis:

Dear Sir: It has not only given me great pleasure, but it has also been of deep interest to me to peruse your professional contribution to medical science, entitled "The Probable Cause of the Limp of the First and Second Stages of Hip-joint Disease." My interest has been naturally aroused by certain mechanical principles that form the basis of the theory that you have advanced. An invitation to discuss this particular feature was gladly accepted, and in studying the proposition I have endeavored to give it my fullest attention. The conclusions are drawn from simple reasoning based upon well known principles of mechanics; and in realizing the impossibility of perfectly grasping and clothing in mathematical expressions the complexity of living locomotors, I have refrained from making anything but the most general statements. * * * The question brought up for consideration is: How is the body supported upon the femur, and what mechanical principles are involved in the construction and functions of the head, neck, and upper portions of the os femoris, together with the pelvic structures, where, in the acetabulum, the joint is formed; and may the arrangements of these parts be compared to what is known in mechanics as the cantilever? * * * The pelvic structure is usually compared to an elastic arch, but it is difficult to see where, in its structural condition, arch *action* can possibly take place. The strength of an arch is due to the fact that its curve cannot be shortened except by compression, provided the ends are prevented from spreading. There would then be *two* conditions absolutely necessary to the stability of such a structure; rigidity of the abutments or supports, and a material sufficiently strong to resist crushing. In the case before us it is the immobility of the supports only that need be considered, and as the femora upon which the pelvic "arch" rests cannot very well be compared to rigid abutments of supports, it is *not permissible* to admit of an arch action. The pelvic structure partakes more of the nature of a *truss*, supported upon brackets attached to the thigh bone. The elasticity of this "truss" acts like a spring, by means of which any extraneous shock from the load is taken up. * * * Referring now to the comparison made with the mechanical principles involved in a cantilever, it is well to state that the term cantilever in its general application has become somewhat ambiguous. The dictionary definitions refer to it as a bracket framed into a beam for the support of a weight, and in that general sense there can be no objection to the employment of the term in the anatomy of the hip and thigh to begin with. In the better defined sense of the term, however, as in the case of a bridge, one of the requirements is that a beam or frame resting upon a vertical beam or pier, extending from it like a bracket, must be anchored at one end extraneously to support a given weight at the other. These brackets have the effect of increasing the range of the pier, and in a cantilever bridge, two of these arms, projecting toward each other from opposite piers, reduce thereby the span of the lateral beam. The maximum extent of the reach of a pier forms the study in the economics of such structures. Now, while this principle is scarcely applicable in the femora and pelvis in the sense of extending the range of the supporting piers in order to reduce the span, nothing whatever can be said against cantilever action. Let us consider the neck with the head of the femur as a short and stout pier, firmly planted upon the main shaft and set obliquely to the base upon which it rests; we may compare the os innominatum to a canting beam, which is anchored exteriorly by means of the thigh abductor muscles, from the trochanter below (representing an extraneous abutment) to the ilium above (representing the beam). No reasonable objection to the application of this principle could be made in that sense. In the case of structural weakness of the femoral neck, the strain upon it from the weight of the superstructure may be relieved by shifting the center of gravity and throwing the load over a structurally more effective support, as in the case of the shaft of the thigh bone. As long as the neck retains its extraordinary stiffness, it will bear and transmit the load without difficulty and inconvenience, but should it be weakened from any cause, the effect would be a tendency to break near its base from the tensile and compressive strains to which the vertical pressure upon the head subjects it, and in order to reduce these, the disposition would be to shift the load as indicated. These deductions would be perfectly reasonable to me on purely mechanical principles. Very truly yours, OTTO VON GELDERN.

SAN FRANCISCO, October 23, 1893.

DR. SHERMAN said: We frequently see a child with a history of a limp one day; none the next; no pain whatever. The next thing in the case may be pain, although pain might be entirely absent even if a huge abscess forms and entire destruction of joint follows. The neck is a weak part. In tuberculosis cases we can crush the bone between the fingers; the putrefactive changes remove the animal substance and leave the beautiful lacework of cancellous tissue. The limp is only an increase of the normal lateral sway of the body.

THE PRESIDENT: Could not an irritation of sensory cells cause a limp, reflexly?

DR. DUDLEY TAIT: I can fully agree as to the absence of pain and still a limp. In patients with chronic sciatica there is often a limp after a cure has been effected.

DR. G. C. MACDONALD: Limp, no doubt, is due to bone sense where we get a typical case; it is not necessarily due to pain. In tabes dorsalis there is no pain. The knowledge of limp comes from bone to spinal cord or brain. For instance, in typhlitis we find the muscles over the region stretched and tense to protect it.

DR. J. F. MORSE: Inquired if bone was conscious of pain, why should not the "bone sense" be felt in sarcoma of the shaft, when often the first knowledge we have of it is a broken limb?

DR. S. STILLMAN: Why not call this a tubercular sense? Why is it necessary to differentiate so finely? Bone is not capable of having pleasurable sensations, but is painful when cut. Why not call it pain? What do we gain by making such fine subdivisions?

DR. SHERMAN, in replying, said: I am afraid Dr. Shiels did not listen carefully to my paper. It was submitted to several engineers. Most preferred to call it a bracket, but it was considered fair mechanics to call it a cantilever action. As to the "bone sense," there is a "muscle sense" that gives us some idea of how much work the muscle is doing, just so there is, I claim, a bone sense showing how much work the bone is doing. If structurally weak, its power to do work lessens. It is a simple appreciation by the central nervous system that the bone is being overstrained. Regarding carcinoma of the shaft of the femur, the strain in the shaft is vertical, and not nearly so apt to be felt as in the neck where the strain is transverse. In construction of buildings, hollow posts or pipes are used as they will bear a greater strain. The shaft of the femur can bear a great many times more than the body weight without breaking. The same limp would result if there were syphilis of the joint instead of tuberculosis. One case that came under my care had the distinct limp. I placed the patient in bed and applied weights. One day later I recognized "Hutchinson's teeth," and put the patient on iodide of potash with very good results. Regarding the painless limp spoken of by Dr. Tait, that is due to muscular weakness. I have seen a child whose limb had been for some time in an apparatuss limp for a long time afterwards. That was due to joint atrophy, and continued until the muscles about the joint became the same size as the others. In these cases, if we do not get the limb to the same size as the other, we have a permanent limp.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, November 6, 1893.

The President, ALBERT ABRAMS, M.D., in the Chair.

DR. C. N. ELLINWOOD read a paper entitled: "Fracture of the Patella and its Treatment by Suture." [Published at page 1.]

DR. C. E. FARNUM said this question of operative treatment of fracture of the patella resolves itself into the practical one of determining whether or not it should be adopted as a general procedure. If decided in the negative, the question still remains in what special cases is the operation indicated? Statistics throw considerable light on the matter, and a sufficient number of cases have been recorded since the adoption of aseptic methods to enable us to generalize without serious error. For example: of 42 cases of suture of the fractured patella, reported by Phelps, in 1890, bony union occurred in all but one, in which close fibrous union took place, with anchylosis, however. The results, then, are satisfactory as regards function, not only as to completeness of range of motion, but in power retained. The only serious objection to suture of the fractured patella lies in the danger. In the 100 cases operated on at Bellevue, mentioned by Stimson (including the 42 cases of Phelps), suppuration occurred in not a single case. There was superficial suppuration in some cases. It is fair to say that when aseptic procedures are properly carried out the danger in the operation is *nil*. The point is, if the operation were prescribed in the text-books for general application, would it be done generally with perfect asepsis? The element of time deserves some consideration. Hamilton says that in the non-operative treatment, the patient should be kept in bed four weeks and should not be allowed to use the leg at all for two months longer. Practically, because of the danger of excessive stretching of the fibrous band of union, the leg is of very little use for six or seven months. Even after this prolonged period of disability, stretching of the fibrous band will occur in amount proportional to its original length. Separation of the fragments immediately following the fracture, is due to the effusion of blood and of serum from the traumatic arthritis, to muscular tension and to the presence of fibrous structures which have slipped down between the fragments. In the final result, the degree of disability is usually proportional to the amount of separation of the fragments. To recapitulate: The decision between operative and non-operative treatment depends on comparison, first, of results, secondly, of dangers. The one gives bony union, the other ligamentous, at best close ligamentous union, but one can never foretell the degree of final separation in any given case. Even close fibrous union is sometimes followed by considerable functional disability. In the 100 cases referred to, the wire caused no trouble. In cases where considerable tension is required to approximate the fragments, wire is to be preferred to catgut, for the latter might stretch out before bony union has taken place. The patella has periosteum only on the one side, so that repair is less rapid than in most other bones. There are serious objections to the operation in old cases in which have occurred shortening of the quadriceps, atrophy of the bone fragments, or shortening of the patella tendon.

DR. GEO. B. SOMERS said he had had no experience in the operative treatment of this fracture, but he was glad to see this change in the treatment coming about. The end sought is of course osseous union, and the impossibility of getting it by non-operative methods because of the invariably-interposed fibrous structures, makes welcome the operation of suture. Another objection to the old method, theoretical to be sure, but perhaps explaining some of the cases of delayed union and the rare occurrences of death of the fragments, is that any pressure sufficient to keep the fragments in contact interferes with their nutrition, for the patella receives its blood supply from the plexus of vessels formed by branches of the anastomotica magna and the articular arteries, beneath which lie the rigid expanded ends of the femur and tibia. The only real objection to the operative treatment is the danger; not an element of the operation itself but dependent on the operator. It is certainly not permissible for the general practitioner. In most successful cases, the operation was performed ten days or so after the receipt of the injury, during which time the synovial membrane undergoes a traumatic inflammation. It is a generally accepted fact that when the synovial membrane has undergone a subacute tubercular inflammation, it is less liable to septic infection than it is in the normal state. Reasoning by analogy, then, it is quite probable that in these operations for fractured patella, the danger of infection is lessened by this delay. It is interesting to note the change that has taken place in the attitudes of the modern text-books on surgery to this operation. The older books do not give it consideration at all. Wyeth says that it is the most unjustifiable procedure in surgery, but in the more recent "American Text-book of Surgery," edited by Keen and White, it is given place among the legitimate procedures. Certainly this operation is not to be done by the general practitioner; in fact, he would do well not to undertake the treatment of such cases at all, but to turn them over to the surgeon who is better equipped for their management.

Dr. L. C. Lane: In my professional career it has fallen to my lot to treat a number of cases of fracture of the patella, and the results were, as a rule, not satisfactory. In nearly all cases I got fibrous union. However, if I were now to decide this question of operation, I should hold that the cases should be classified. In most cases the upper fragment is drawn upward to an extent dependent on the amount of laceration of the structures containing the patella. I have found that when the fracture is by direct violence, as in a fall on the curbstone, there is but little displacement, and in treating such cases you will always get a good result. Not so with the other cases; the treatment here is very tedious, and the result imperfect. I have used many appliances but have found the most satisfactory to be a posterior splint and adhesive strips, with occasional passive motion. I remember well a case that occurred in my practice years ago. The man got well and could walk on a level, but was insecure in going up or down stairs, and he was greatly dissatisfied. Dr. Toland was called in consultation and pronounced the result a good one. Not satisfied with this, the man went about the town trying to find some one to say that the result was a poor one. While so doing he fell, broke one of the fragments, and was taken to St. Mary's Hospital, where extensive sloughing occurred with complete loss of the patella, but strange to say, he got well, with a very good leg, without a patella. A recent writer in Volkman's *Klinische Vorträge*, Klemm, of Riga, refers to the work of König, Macewen, etc., who show that the trouble is due to the interposition of a part of the capsule between the fragments; and to a German, Tilanus, who used nothing in the world but massage. Bergman is opposed to the operation except in certain cases. Klemm's plan, following Tilanus, is to knead the limb for 60 or 80 minutes to get up an action of the lymphatics in the thigh, when he fixes the parts with strips of adhesive plaster. This process is repeated daily. In the four cases reported, perfect cure as to function was obtained in 25 days. However, Klemm admits that where the tendon is completely torn across, massage alone is not sufficient, and that such cases must be operated upon. One could not have had a better demonstration of a successful case of patellar suture than that presented to-night. Dr. Ellinwood is to be congratulated on his result.

Dr. Basil Norris said we are too apprehensive about our cases of fracture of the patella. Many cases get well with very good results under very bad treatment, or with no treatment at all. He detailed the history of a case in a hysterical woman, who persistently tore off the bandages he applied, and who got well with a limb which she could use in later years, even in going up stairs.

Dr. R. W. Murphy referred to a case of wiring the patella, which he had seen in early days in San Francisco, by Dr. Logan, who learned the operation from Dr. E. S. Cooper. Personally, he had had two cases of fracture of the patella. In the first he got a partially successful result, but in the second there was bony union. He wrapped a cord with an ordinary bandage, and tied it around the thigh, passing the end to the sole, where it was fixed to a stirrup. A long splint was placed on the side of the leg, so that flexion could not take place, and the result in six weeks was bony union with perfect function.

Dr. Ellinwood, in replying, said it had been objected that cat-gut was not strong enough, and that wire should be used in cases where tension was great. In these cases, where the resistance was too great to permit of facile approximation, the tense parts should be divided.

Demographism and Chronic Urticaria with Glycosuria.—**Dr. A. Abrams** presented a young man to the society, who showed the very interesting phenomenon that tracings made with a blunt point on the skin were brought out in relief. The word urticaria, traced on his arm with the blunt end of a match, could be read distinctly at some distance. This cutaneous phenomenon was described as dermographism. It was dependent on an hyperesthetic condition of the vaso-motor nerves. In delicate-skinned individuals, especially hysterical females, dermographism might be present, but rarely so marked as in this case. The speaker had examined many hundreds of persons, but in the majority of instances the phenomenon was very evanescent, even if it could be evoked. Dermographism was also present in cases of urticaria, and the phenomenon was known as urticaria factitia; but, in this case, there never was an urticaria; in fact, the discovery of the phenomenon was purely accidental. The speaker next presented a case of chronic urticaria. He contended that the nosology of this disease demanded revision. It was not a skin disease, no more than was erythromelalgia, Raynaud's disease or angio-neurotic edema. It was, in fact, an angioneurosis. He wished to direct attention to a complication noted in this case, which was unparalleled, as far as he could ascertain in the literature on the subject. This complication was glycosuria, which persisted after the paroxysm of urticaria. In explanation of this symptom, he advanced the following theories: (1) That the irritation of the vasomotor center in the floor of the fourth ventricle, from whatever cause, was sufficiently great to extend by continuity to the adjacent diabetic center, irritation of which will produce, as is well known, glycosuria. (2) That in urticaria there was a dilatation of the arterioles of the liver, which would necessarily accelerate the flow of blood through this organ. Thus, the sugar would not be stored as glycogen, but, passing directly into the blood, would be excreted by the kidneys.

SPECIAL CORRESPONDENCE.

HEIDELBERG.

The Advantages of the Smaller Cities as Educational Centers for the Beginner. The Freiburg Eye Clinic.—The Eye Clinic of Heidelburg.—Prof. Jurasz's Nose and Throat Clinic —The Obnoxious American Abroad.—Prof. Moos' Ear Clinic.—Weber of Darmstadt.—His Canaliculus Knife and Cataract Operation.—The Ophthalmological Congress.—The Removal of the Lens for Myopia.

Many Americans going abroad for the study of a specialty, commit the error of selecting one of the larger centers of education, such as Vienna or Berlin. While, for one who has already had some experience, and who goes to Europe merely to learn the newer methods, the opportunities in the larger cities are better; still, for the beginner, who must go through the drudgery of perfecting himself in methods of examination, they are quite unsuitable. The cursory examination of too many patients is likely to render the student careless. The beginner, who attempts to assimilate all the material in one of these enormous clinics, is seized with a sort of mental indigestion; and becomes discouraged by his inability to detect the pathological conditions, which he is told are present. Universities such as Freiburg and Heidelburg, are visited mostly by students of general medicine; hence, one pursuing a special course, receives great encourment, and is granted the privilege of attending clinics, which, especially during the vacation, in the absence of the students, are extremely valuable. I have met several men who have visited the larger clinics and afterward discovered their error. Without being able to sound the larynx, make a proper insufflation, or thorough examination, they had been attempting operations. As one expressed it, "I have been operating upon nasal polypi that I never saw." In the smaller University clinics, the material is ample for study, and the student, not being disturbed by a throng of patients eager to be treated, can persist in his attempts until thoroughly satisfied as to the diagnosis.

The Freiburg Eye Clinic, which I first visited, is under the direction of Geheimrath Mauz, chiefly known through his work upon "The Embryonal Development of the Eye." Although the clinic is not a large one, there is ample material for study, there being seldom many visitors present. The Director and his assistants are always ready to render the novice any assistance necessary. The methods pursued there present none of the startling and somewhat hazardous innovation of the younger school of oculists; but afford opportunities for a thorough, systematic acquaintance with the ground-work of the art. Antisepsis, as carried out in the Freiburg clinic, is not of the most thorough nature. Before operating for cataract, the conjunctival sac is carefully irrigated with sublimate solution, and, if indicated, the lachrymal passages are also cleansed. The instruments were formerly dipped in carbolic solution and afterwards dried; but, at present, are treated by sterilization, the direction tending constantly toward a more thorough asepsis. In certain selected cases, the operation is made without iridectomy; however, in by far the greater number, an artificial coloboma is made. The cystotome is used for opening the capsule, and secondary cataract is treated promptly by discission.

In the Eye Clinic at Heidelberg, the patients are visited in the wards each morning, instead of being summoned to the clinic room, as at Freiburg. Geheimrath Leber is followed upon his visit by his three assistants, and from one to three visitors. The ambulatory clinic is handled by the assistants, cases of special interest only being referred to Prof. Leber. One desiring practice in examination of the refraction, has ample material here, and the assistants gladly refer patients to a volunteer. The number of patients treated averages four thousand a year. The operative measures are similar to those employed in Freiburg. Cataract extraction is always accompanied by iridectomy. The opening of the capsule, however, is done with the capsule pincette, which, by removing a portion of the capsule, renders the formation of secondary cataract less likely to occur. Notwithstanding this manifest advantage of the pincette, it seems an awkward instrument to handle, and necessitates a certain pressure upon the lens, with the accompanying danger of the rupture of the zonula. The patient's eyelids and the immediate neighborhood of the eye are washed with soap and water, and then moistened with sublimate solution 1:5000. The instruments are placed in 5 per cent. carbolic solution half an hour before the operation, and, afterward, transferred to a 2½ per cent. solution. The rule for cocainization is a very good one, and anesthesia is always complete. One drop of a 5 per cent. solution of cocain is dropped into the eye every minute until 5 drops have been used. By this time the insensibility of the cornea is complete and the annoying complication, incomplete anesthesia, is never experienced here. By far the greatest importance of the Heidelberg clinic lies in its contributions to scientific work. The large, new laboratory has just been completed, and the vast number of collected and classified pathological specimens, together with the work-rooms devoted to experiments upon animals, render this clinic, at the head of which is the greatest eye pathologist of the world, unparalleled for scientific research. A *sine qua non* is a knowledge of the German language. Prof. Leber will receive no students who are without a speaking and understanding knowledge of that tongue. At present, only those desiring to pursue a special branch are received in the laboratory; but doubtless, during the coming semester, courses in pathology of the eye will be given by the first assistant.

A very valuable clinic for those commencing the study of diseases of the nose and throat is that of Prof. Jurasz. Graduates are received as volunteers and allowed to examine and treat cases. A slight knowledge of the *technique* is, however, necessary, and this is afforded by the clinical course, with practice upon trained subjects. So soon as the visitor has acquired the necessary skill, he is allowed to perform all minor operations upon the throat and nasal passages. Prof. Jurasz, who is one of the most agreeable of men, is pleased to receive all visitors, save such of our countrymen as, upon a certain occasion, paid him a visit, and upon being offered cases for examinations, remarked that "they had no time therefor; they wished only to know what he prescribed, and to obtain copies of his prescriptions."

Apropos of this type, which has made the standing of American physicians an unenviable one here, and rendered the obtaining of privileges more difficult, a good story is told in the physiological laboratory. There appeared suddenly, one day, at this institution, an individual of theatrical appearance, who inquired in a loud voice for Professor "Koone." Prof. Ewald, the gentleman addressed, replied, "You mean, probably, Geheimrath Kuehne." "Yes," said the visitor, "are you Ewald?" Had this person been of less bold and striking mien, he doubtless would have been refused admission to these sacred precincts. He seems, however, to have overawed the "Gelehiten," who granted him a place for the pursuance of his study upon the "Histology of the Nervous System." Although he had not done any previous work in this line, and had no knowledge of the anatomy of the central nervous system, he began at once a microscopic examination of the nerves. After contemplating for a short time a specimen which he had placed under the microscope, he arose suddenly with a loud "Hurrah? I have made a discovery. The nerves move." His cry of triumph was met by a grunt of disgust from Hofrath Kuehne, who, however always ready to learn, deigned to glance through the microscope. What he saw there was a nerve fibril swimming under the cover-glass in an excess of fluid. The career of this candidate for honors, as a specialist for nervous diseases, and who, as it afterward appeared, was a product of that exotic institution found so often in our fertile land—the two term college, was short. A subsequent attempt to pursue his studies in Frankfort, resulted in a like failure.

Another such representative of our educational freedom, who is continuing his studies here as specialist for all forms of disease, recently remarked, "I had a splendid course in ophthalmoscopy in New York. I was then able to see and identify all parts of the background of the eye. Were you to show me a chart of the fundus, although I have forgotten much, I would recognize and designate the various parts that I had previously seen, although I might confuse the macula and papilla." This was not intended as a joke; it was said in all earnestness. The same individual has been amusing his colleagues during the past semester by his wise sayings in the clinic of Prof. Erb.

The ear clinic under the direction of Prof. Moos is very unfavorably situated, and does not boast of a large number of patients. However, otology being one of the elective studies, and this clinic not being a popular one, the visitor has an opportunity for exact study scarcely to be duplicated elsewhere. The assistant, who is somewhat pedantic by nature, takes the visitor in hand, and releases him only when the facts are absolutely clear to him. The director, Hofrath Moos, notwithstanding the immensity of his scientific knowledge, is not very active in his treatment, and is greatly hampered in his work by the fact that he is exceedingly *deaf*. The visitor is confronted by a notice in the hallway that informs the public at large that "physicians are allowed to visit the clinic only twice without making the necessary arrangements." However, the fee is a small one, and the professor has been known to offer cut rates.

I had the privilege lately of making the acquaintance of Geh. Weber, of Darmstadt, whose name is inseparably connected with many operative procedures, chiefly upon the lachrymal passages. In response to an application to the Heidelberg Eye Clinic for a substitute, I took charge of the practice of Dr. Albrecht Weber for two weeks, the son of the celebrated oculist of the same name. Dr. Weber is the last of that illustrious circle which embraced in its numbers Donders and Graefe. His fund of reminiscences is a rich one. He related, in a most vivid manner, how Donders first expounded to them as they sat together one evening his discoveries in regard to the refraction of the eye; and how amazed they were at its simplicity and clearness.

Speaking of his well-known canaliculus knife, he said the Weber knife had no button upon the end, simply a thickening toward the point and a blunting of the cutting edge, in proof of which the originals were shown. Those now sold under his name he repudiates. He still practises the "Weber cataract operation," as described by him many years ago. The difficulty of the operation, and the almost impossible task of sharpening the hollow triangular knife, are against its general adoption. As he does not operate during the warm season, I had no opportunity of observing his results, which he claims are incomparably fine. Dr. Weber is a man of great creative ability; as von Graefe said of him: "He has ideas;" however his lively imagination leads him to see everything tinged with a roseate hue, and when he claims "full vision" after cataract operations, one is apt to believe that there must be many cases "that don't count."

The recent Ophthalmological Congress here proved to be of considerable interest. Amongst the notables present were Leber, of Heidelburg, Fuchs, of Vienna, Sneller, of Utrecht, von Hipple, of Halle, Uhthoff, of Marburg, and Schmidt-Rimpler, of Góttingen. There was a large array of assistants from all parts of Europe, and last, but not least, Dr. Rosa Kerschbaumer, of Salzberg. Many pleasant acquaintances were made, amongst the number that of Dr. von Hoffman, brother of the well-known San Francisco gynecologist, who has a large clinic in Baden-Baden.

Many interesting papers were read at the sessions, which were held in the University's Aula; but probably the greatest interest was aroused by the paper of Dr. Fugala upon "Removal of the Lens for Myopia." The results given were very gratifying. He was supported by Dr. Thiers, of Aachen, who gave even more astonishing figures. In response to inquiry by some of the older and more conservative members for a detailed description of his operation, which, in principle, is a discission with subsequent extraction as in soft cataract, he remarked that, instead of using a needle, he passed a Graefe's knife through into the vitreous, severing the lens completely in twain. Looks of astonishment, not to say incredulity, were depicted upon the faces of many present. A former assistant of Thiers, who is now acting in like capacity for Prof. Leber says that he knows many of the cases and can testify to the results. Prof. Pfluger's assistant from Berne also gave testimony to the marvelous effect of the operation as practised in their clinic. Prof. von Hipple had operated on a few cases, but had been somewhat disappointed in the result. All the operations, however, were of recent date. Prof. Raehlmann, of Dorpat, was inclined to think the procedure radical, but had had no personal experience. As to the class of cases suitable for operation, the advocates of this procedure were not agreed, however. They united in saying that it should be done only in high-grade myopia, with a tendency to progression and without serious alteration in the background of the eye. They considered it better to operate on only one eye. The well-known prevalence of myopia in Germany will probably give greater opportunities for testing this method than in our own country where myopia seems not only much less prevalent, but also of lower degree.

December 1, 1893. A. B. McKee, M. D.

REVIEWS AND NOTICES.

A. S. Aloe & Co. have recently issued a catalogue that is a great improvement on anything that this firm has hitherto attempted. The volume is much larger than the average work of this kind, and is neatly and substantially bound in cloth. The typographical work and the engravings are good, and an effort has been made to keep the illustrations on the same page as that containing the description of the instrument. The great departure is in the complete elimination of the discount system. With a few exceptions the figures given are net, and there is no need for further calculation. The book will be sent free to any physician guaranteeing express charges, or by forwarding the publishers 50 cents.

The Physician's Visiting List for 1894 (forty-third year). Philadelphia: P. Blakiston Son & Co. Price, according to style, from $1 to $3.

This old and familiar favorite comes to us in the form that increasing favor with the profession has served to perpetuate. The miscellaneous information has been revised, but the plan of the work is the same as that which originally made it so popular. A careful inspection of its competitors shows that it has no superior.

The International Medical Annual and Practitioner's Index for 1893. Edited by a corps of 38 department editors—European and American; P. W. Williams, M.D.; Secretary of Staff. Illustrated. New York: E. B. Treat. pp. 626. Price, $2.75.

The eleventh annual volume of this valuable work of reference was promptly issued. Improvements have been added from time to time, but the general character of the work has remained unchanged. The illustrations are more numerous, and colors are more freely used. The alphabetical arrangement of the contents, the complete index, and the convenient size of the book, together with its very reasonable price, place it within the reach of all.

E. B. Treat, the New York publisher, has in press for early publication the 1864 *International Medical Annual*, being the twelfth yearly issue of this eminently useful work. Since the first issue of this one-volume reference work, each year has witnessed marked improvements; and the prospectus of the forthcoming volume gives promise that it will surpass any of its predecessors. Illustrations in black and colors will be consistently used wherever helpful in elucidating the text. While the book will be so much improved over previous issues, the price will remain the same as heretofore, $2.75. Amongst other works in press is a new and enlarged edition of "A Manual of Clinical Diagnosis," by Dr. Albert Abrams, of San Francisco.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held December 7, 1893, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

Wm. Allen, Redlands; Univ. Edinburg, Scotland, Aug. 1880
James Holmes Barr, Marysville; Chicago Med. Coll., Illinois, Apr. 29, '90.
Frank Austin Bowman, Smith River; Cooper Med. Coll., California, Dec. 6, '92.
Levi Chase, San Diego; Bellevue Hosp. Med. Coll , New York, 1869.
Miles Brecht Cook, Los Angeles; Med. Dept. Western Reserve Univ., Ohio, Feb. 20, '77.
James Edmund Downs, San Francisco; Rush Med. Coll., Illinois, Feb. 19, '89.
James Forney Dungan, Exeter; Vanderbilt Univ., Tennessee, Mar. 1, '91.
James Stewart Glass, Seml; Detroit Med. Coll., Michigan, Mar. 4, '85.
Joseph H. Grier, Los Angeles; Med. Dept. Univ. of Pennsylvania, Mar. 14, '61.
Garret L. Hogan, Los Angeles; Albany Med. Coll. New York, Mar. 16, '87.
Gustav Howe, San Francisco; Med Coll. of Ohio, Apr. 6, '93.
Philip Mills Jones, Alameda; Long Island College Hospital, New York, Mar. 12, '91.
W. W. Lathrop, San Francisco; Med. Dept. Univ., Michigan, June 26, '84.
John L. Livingstone, Los Angles; Mich. Coll. of Med., Michigan, Mar. 5, '83.
Emil Lorentz de Corval, San Francisco, Long Island Coll. Hosp., New York, Mar. 9, '88.
Nicholas K. Noon, San Francisco; Kansas City Med. Med. Coll., Missouri, Mar. 20, '93.
B. F. Rafferty, Pleasanton; Jefferson Med. Coll., Pa., Apr. 2, '86.
Geo. M. Randall, Pasadena; Marine Medical School, Bowdoin College, Maine, May 27, 89.
John James Sellwood, Forbestown Med. Dept. Willamette Univ., Oregon, Apr. 13, '87,

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from November 20, 1893, to December 20, 1893.

First Lieutenant Chas. Willcox, Assistant Surgeon, will be relieved from temporary duty at Angel Island, Cal., on the arrival there of Major Benjamin F. Pope, Surgeon, and will report in person to the Commanding Officer at Boise Barracks, Idaho.

First Lieutenant Francis A. Winter, Assistant Surgeon, is relieved from further duty at Fort Wingate, New Mexico, and from temporary duty at Fort Bayard, New Mexico, and will proceed to new Fort Bliss, Texas, and report in person to the Commanding Officer for duty at that station.

ITEMS.

Dr. Alfred E. Regensburger has resumed his practice at No. 330 Sutter street, between Grant Avenue and Stockton street, San Francisco.

Dr. R. Harvey Reed, who edits the Department of Surgery in the *Railway Age,* has removed from Mansfield to Toledo, Ohio, where he holds several appointments.

Dr. A. Jacobi, the Chairman of the American National Committee of the Eleventh International Medical Congress, has received the following communications from the Secretary-General: Papers to be read in any of the Sections of the Congress should be announced on or before January 31st, 1894, to the Secretary-General, Prof. E. Maragliano, Ospedale Pammatone, Genova, Italy. The title of the paper ought to be accompanied with a brief abstract of its contents and conclusions. The programme to be distributed will contain the titles of all the papers announced before August 31st, 1893, and since. The reductions granted by the railway companies months ago will be available from March 1st to April 30th, 1894. "Traveling documents" will be sent to the address of every subscriber on or before February 15th, 1894, and after that date congressists will have to apply to the undersigned. In the interest of such medical men as will sail for Europe before official cards will have been received from the General Committee, Dr. Jacobi proposes to supply in as official a form as he thinks he is justified in doing, credentials which are expected to be of some practical value. It is suggested, besides, that a passport may increase the traveler's facilities. Members' dues are five dollars (money order to Prof. L. Pagliani, Rome), guests' (wives and adult relations) two dollars, medical students: no fees. All are entitled to traveling documents.

Occidental Medical Times.

Vol. VIII. FEBRUARY, 1894. No. 2.

THE PATHOLOGY AND LOCAL TREATMENT OF PUERPERAL ENDOMETRITIS.

By Wm. Fitch Cheney, B.L., M.D., Adjunct to the Chair of Obstetrics, Cooper Medical College.

Read before the San Francisco County Medical Society.

Much has been learned about puerperal infection during the past fifty years. Vast strides have been made toward determining its causes and explaining its manifestations; and hand in hand with this progress, has come knowledge of the way to prevent the disease and to diminish its former ravages. Investigation on this subject, particularly as regards the question of pathology, is constantly going on, so that much of it is now more recent than the text-books on obstetrics in general use. Because this investigation is of the greatest value, not only from a theoretical but also from a practical standpoint, I have thought that a review of what is being found out, might be of interest to this Society. Germany and France have given the most important of recent contributions to the knowledge of puerperal infection. Most prominent among the investigators in Germany, in this particular line, is Bumm, of Würzburg, who has done more than any other to clear up the pathology; but his work has been reinforced and corroborated by that of Leopold, Gärtner, Kroenig, and others. In France, the most valuable contributions have been made by Widal, Chantemesse, and the famous Bouchard. All the writings on the subject, considered in preparing this paper, have appeared within the last four years.

It has been found, first of all, that in the great majority of cases of puerperal sepsis, the endometrium is the port of entrance into the organism for infectious germs. It is not denied that infected perineal, vaginal, or cervical wounds may give rise to fever and even lead to general sepsis; but this is the exception. Usually the infection of these wounds is limited to them, and the germs do not get far outside, into the surrounding tissues. On the other hand, in every case examined by Bumm and Widal, where death resulted from general sepsis, the germs could be traced into the body from the endometrium. Puerperal endometritis thus becomes a pathological condition most necessary to be understood, and one particularly to be borne in mind in treatment.

Bumm, following the classification of Kehrer, according to the etiology, divides puerperal endometritis into two kinds—Putrid and Septic. *Putrid endometritis* is due to the action of saprophytic microörganisms, such as flourish on decaying animal or vegetable matter anywhere. It is not necessary to their growth that fragments of membrane be retained in the uterine cavity, and as for septic germs, they play no part in this process. These saprophytes produce a degeneration of the decidua. Sometimes they affect only its uppermost layers, which are cast off physiologically, during regeneration of the mucous membrane, without germs and without putrefaction; but sometimes they extend more deeply into the decidual tissue. The chemical products of the putrefaction they induce, are absorbed into the circulation, produce elevation of temperature and the other symptoms of putrefactive intoxication. Wherever the saprophytes extend over the mucous membrane, it is found in a condition of necrosis and disintegration; but beneath this zone of necrosis follows a layer of cellular infiltration, made up of small, round cells, which are simply white blood corpuscles that have wandered out from the vessels. These lie closely packed together, forming a wall that separates the necrotic decidua from the muscular tissue beneath. Through this wall the microörganisms nowhere pass. It separates the dead from the living elements, and marks the point at which nature successfully marshals her forces to repel the invading host. In putrid endometritis, therefore, there is no passing of microorganisms into the circulation, but merely an absorption of the chemical products of their activity within the endometrium.

Septic endometritis, on the other hand, is characterized by the settlement upon the decidua of the well-known microbes of human sepsis—staphylococci and streptococci. By far most frequently the streptococcus is the cause of septic endometritis. Czerniewski has demonstrated this for patients in lying-in institutions; Bumm says it is true in private practice as well. The two forms are often present together, but seldom is the staphylococcus found alone, and then only in mild cases, running an easy course, as Fehling has observed. Even with these malignant germs colonized inside the uterus, the pathological findings are not always the same. Hence the condition has been subdivided into (*a*) localized septic endometritis, and (*b*) septic endometritis with subsequent general infection.

In *localized septic endometritis*, the infection remains limited to the endometrium. Here again the decidua becomes permeated by germs, but this time by the characteristic chain cocci, instead of the comparatively harmless saprophytes. The effect of this, as before, is necrosis and disintegration; but beneath the necrosed layer the same round cell infiltration takes place, and a granulation wall is formed between the disintegrated decidua and the muscular tissue. Into this granulation layer the cocci do not penetrate. It acts as a barrier here, to the pathogenic streptococci, just as in putrid endometritis, to the germs of putrefaction. The fever observed in these cases must, therefore, also be attributed to absorption and resorption of chemical products of metamorphosis, formed in the necrotic layer by the streptococci or staphylococci; and not to direct passage of microörganisms into the circulation.

In *septic endometritis with subsequent general infection*, the wall of granulation tissue has been broken through by the germs. It has formed, and its ruins can be seen; but it has been destroyed and beaten down. This result accomplished, the victorious streptococci take one of two roads in their passage onward through the uterine wall—the lymphatics or the veins. If they take the former, they can be traced in stained microscopic sections, following now the coarser, now the finer lymph channels, from the necrotic decidua directly through the uterine wall, between the muscle fibers, until at last they reach the serous surface of the uterus, there to set up a peritonitis and thence to be carried to every part of the body. Bumm examined one such case, where death resulted on the fourth day from septic peritonitis, and succeeded in cultivating streptococci in large numbers, not only from the endometrium, but from the peritoneal fluid, the blood, the spleen, the liver, and the kidneys. In these cases, where the germs follow the lymph vessels in their passage through the uterine wall, the placental site has most of its veins well closed, and free from thrombi and cocci; only some of the smaller venous lumina contain thin plugs of blood, in which are a few germs. The lymph vessels, on the contrary, are perfectly filled with cocci, as if injected with them; and from these as foci the infection spreads into the neighboring muscle tissue, which there becomes necrotic and degenerated. White blood corpuscles wander into this necrotic tissue surrounding the lymph vessel, changing it to a pus cavity, and thus result the abscesses sometimes found, *post-mortem*, in the uterine wall. The journey from the endometrium to the peritoneum is, as a rule, made by the germs directly through the wall, and only rarely through the fallopian tubes; in most cases the latter remain free from germs, and their mucous membrane sound. There is found to be a physiological stenosis at the ostium internum tubæ, which normally shuts off advance of the cocci along the tube lumen; and only in pathological conditions, which have made the tubes unusually patulous, does infection of the peritoneum take place through them.

When the streptococci choose the veins instead of the lymphatics for their onward march; the condition of the endometrium is the same as already described. It is everywhere permeated by germs, necrotic, and all its previous structure broken down into a smeary mass. The necrotic layer is well separated from the sound tissue by the reaction layer of nucleated round cells, into which the germs do not penetrate. The lymph vessels are entirely free from germs. At the placental site, even when separation has been perfect and no placental fragments remain, the veins are found to be filled with thrombi, which can be traced from the free surface of the uterine cavity clear through to the ligamenta lata. These thrombi are invaded by the streptococci, and along them the latter pass, now following the axis of the vessel's lumen, now spreading out into the periphery and even to the vessel wall. With their spread, the substance of the thrombus quickly becomes disintegrated. The closer the germs approach the vein wall, the more it becomes infiltrated with round cells. Then some of these cells wander into the vessel lumen, which finally contains a mixed detritus of the remains of the thrombus, leucocytes and germs. The veins of the ligamenta lata are also filled with infected thrombi, which present the same appearance as those in the uterine wall.

In looking over these pictures of the pathological changes presented in puerperal endometritis, several important points stand out. (1) The endometrium, where the germs have settled and developed, is, in all forms of the affection, changed into a necrotic layer. (2) In every case this necrotic germ zone is separated by a wall of round cells from the sound tissues beneath, representing the effort of nature to protect the organism from further invasion. (3) In simple putrid endometritis and in localized septic endometritis, this wall proves fully competent to prevent the germs from advancing, and at no point do they succeed in penetrating it. (4) In the cases where general infection takes place through the veins, the protecting wall of round cells still operates to check invasion at all points except the placental site, where the plugs of clotted blood afford a suitable culture medium for the germs. (5) In the cases where general infection takes place through the lymphatics, and in these cases alone, does the wall of round cells prove entirely powerless to resist the advance of the streptococci, which beat it down and swarm through the gaps to overrun the whole body.

In every case the infecting germs concerned in puerperal endometritis are the same—the staphylococcus and streptococcus, and the same wound surfaces exist in all; how then does it happen that at one time the infectious process remains localized, at another the germs make their way through the venous channels, and at another through the lymphatics? It was at first thought by investigators that an explanation could be found in varying personal capability for resistance, which showed itself in different individuals as perfect, relative or entirely lacking immunity against the streptococcus. But this theory has been abandoned, and it is now assumed that all women in labor have an average degree of susceptibility for the septic poison. The chief cause for the varying course of the infection is, therefore, considered to lie in the pathogenic agents themselves. The number of germs present does not play a part—Bumm could distinguish no essential difference in the amount of them shown by the necrotic decidua in mild and in severe forms; and it is known, also, that the smallest quantity of septic material, from the most minute wound, can cause the most severe form of sepsis. The only explanation remaining is, therefore, this—that the virulence of bacteria varies. This point is urged by Widal and Chantemesse. By virulence they do not mean a property independent of other life functions, an increased manifestation of poisonous qualities, but rather a greater capability of resistance, an increased power of all their functions, which makes the germs able to overcome the harmful influence of the body tissues and juices, and in spite of these to multiply. Thus, in localized septic endometritis, and to a certain extent in the thrombotic form of puerperal infection, the germs are assumed to be of relatively weak virulence, while in the lymphatic form they are able to overcome the local reaction, because of their greater virulence against which the organism proves powerless.

It remains to call attention to the bearing of these investigations on the question of local treatment. The most important lesson appears to be that it is possible to do more harm than good in the effort to get rid of the germs; for, in most cases of puerperal endometritis, nature, unaided, is able to prevent their advance beyond the endometrium. Except in the most violent types of the disease, the symptoms are due wholly to the absorption of chemical products from the interior of the uterus; only such treatment, therefore, as helps to remove these toxic products, and does not at the same time disturb the barriers that keep out the germs themselves, can be indorsed as justifiable. The best results are attained by local treatment in putrid endometritis, and as a rule douching the uterus with boiled water suffices here to remove the fetid odor of the lochial discharge and to produce a rapid fall of temperature. Bumm made bacteriological examinations of the lochia after intrauterine injections with boiled water, and again after injections with disinfecting solutions of sublimate, carbolic acid and lysol. He found that after allowing twenty-four hours to elapse, the lochia showed just as many germs in one case as in the other. If the temperature once more rises and the discharge again becomes foul after washing out the uterus, the process is to be repeated. Frank recommends that the intrauterine injection be kept up much longer than is usually done, until a gallon and a half or two gallons of sterile water have been used.

The curette should come into consideration only after douches have failed. If the case is one of pure putrid endometritis, the curette can only do harm by breaking down the protective layer of round cells beneath the necrotic decidua. In localized septic endometritis the same is true; and if it is doubtful whether the germs at work are saprophytic or septic, as must often be the case, the douche should always first be tried, and the curette reserved for a last resort. If a curette is used, it should be a blunt one; for this will serve to remove all the soft, disintegrated decidual tissue, without danger to the subjacent muscular wall. The chills and increased temperature that not uncommonly follow the scraping out of the puerperal uterus, are due to the mechanical action of the curette, in pressing the products of putrefaction or the septic germs deeper into the tissues, where absorption more readily takes place. This can be prevented, it is found, by thoroughly washing out the uterine cavity with boiled water before the instrument is introduced. Thus in any case the intrauterine douche comes to play a most important part in local treatment.

Recently much has been said in favor of the iodoform gauze tampon for the uterine cavity. Fritsch recommends it in puerperal endometritis, following the douche. It acts here as in any wound, as antiseptic and stimulant to healthy granulation processes; but its main advantage in these cases is the drainage it affords. It seems probable that much of the intoxication symptoms in puerperal endometritis come from retention of discharges, especially when the position of the uterus following labor is one of anteflexion, as frequently occurs. The gauze strip, running from the fundus to the vagina, provides a constant outlet for infected discharges and prevents accumulation. There seems no good reason why the surgical principles applicable to other wound cavities should not be applied to the uterus after labor, and free exit for all secretions, with cleanliness of the granulating surface, are as necessary in one case as in the other. Hence the gauze tamponade and the aseptic douche appear to be rational local treatment.

It is true, however, that the uterine cavity sometimes differs from other wound cavities, in having bits of dead tissue left clinging to its wall, after incomplete expulsion of placenta and membranes. This is made the excuse for many an attack with curette or other instrument, when the first elevation of temperature occurs. There are several facts to be borne in mind in this connection, that recent investigations have brought out: (1) That retention of fragments after labor at full term is by no means so common as is generally assumed —in fact, it is the exception here, though common enough after abortion. (2) That such retention is in no way necessary to the colonization and growth of either saprophytic or septic germs, which find in the decidual membrane all the soil they need. (3) That even if such fragments do remain, nature alone is able gradually to throw them off, by a process of reactive inflammation, without serious harm to the organism. If now, on mere suspicion that such fragments have been left within the uterus, a curette at once be used to remove them, an unnecessary and unjustifiable violence has been done, if no such fragments were really there; and if they are found and removed, the entire decidual surface has at the same time been scraped away, and a much larger raw surface created than existed before, with correspondingly increased opportunity for general infection. Such treatment must often do far more harm than good.

In septic endometritis, the results of local therapy are always uncertain. It has long been observed that methods one time giving good results, will, on another occasion, fail entirely, no matter whether resort be had to disinfecting douches, to curetting, to iodoform gauze tampons, or to any other plan. These varying results are now explained by the unequal virulence of the streptococci at work, which quality is manifested not only in the ease with which they overcome the local reaction within the uterus, but also in the resistance they offer to means employed from without to destroy them. Sometimes they are easily dislodged and rendered harmless; but again they penetrate very quickly into the tissues and stick there firmly, despite all antiseptic measures. Schimmelbusch has recently published experiments on animals, which show that even though a freshly infected wound was immediately subjected to disinfection, this did not suffice to check the advance of the streptococci, which at last caused the death of the animal. Such experiments throw much light on the occasional failure of all methods of treatment to accomplish good in septic endometritis.

It must also be borne in mind that sometimes the local treatment not only fails to aid, but really makes matters worse. It does this by producing new wounds in the endometrium, tearing open those already closed, disturbing septic masses which have begun to be encapsulated or breaking loose infectious thrombi. A chill may follow a simple intrauterine injection, and elevation of temperature, with other symptoms of parametritis or peritonitis, at once supervene. In October, 1892, a paper was read by Schrader before the Obstetrical Society in Hamburg, in which he strongly advocated that local treatment of puerperal endometritis be entirely omitted. He claimed that mild cases would recover without it, and more severe cases were either not helped or were made worse by intrauterine measures of any sort. This rather unusual position was upheld by many others, in the discussion that followed. Lomer said that in Berlin, with a large amount of material at hand, he had lived through the irrigation period, and from permanent irrigation of the uterus he had never seen good but much evil result, while even from occasional irrigation he had learned to abstain more and more; he did not believe the puerperal uterus should be interfered with, even to remove remnants of membrane. Credé, he said, had demonstrated by a large number of cases, that it was better to let the uterus alone. Grapow, in the course of the discussion, expressed the quandary in which many a man finds himself placed: if he irrigates the uterus and the patient dies, then he attributes the death to irrigation; but if she dies without irrigation, he believes irrigation might have saved her. In both cases he is a scapegoat, one time because he committed an act, the other because he omitted it. It yet remains to be decided which position is the more pleasant.

In concluding this paper, I would state that the only attempt has been to give some account of the work being done and the views being expressed on this subject by authorities. Many questions in obstetrics yet remain open, and a procedure at one time regarded as the quintessence of progress, may ten years later be rejected entirely. Without being able to fix the limits exactly as to what shall or what shall not be done in local treatment of puerperal endometritis, it must be observed that our growing knowledge of the pathology emphatically teaches conservatism, and urges upon us greater confidence in the *vis medicatrix naturæ*. In the words of the illustrious Credé: "First we learn what to do and how to do it; but only later and with much more difficulty, do we find out what *not* to do and how *not* to do it."

906 Polk street.

THE UTERINE CURETTE; ITS USES AND ITS LIMITATIONS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal.

Read before the California Northern District Medical Society.

A consensus of opinion as to the proper form, uses, and limitations of the uterine curette has not been reached. The sharp, the medium, the dull curette; the plain, the irrigating; the stiff, the flexible; the fenestrated and the solid, each has its partisans. The indications of the curette, as promulgated by different authors, are hardly less various than its forms. With some the curette is indicated in almost every variety of metritis and endometritis, with others it is indicated in the fungous or hemorrhagic variety only; while between these extremes every possible shade of opinion is entertained.

The limitations of the curette are also undetermined. By some curettage is regarded as generally curative, by others as generally palliative. It shall be the purpose of this paper to consider these opinions, and, in as far as possible, to rate them at their real value.

To be a safe instrument, of the highest convenience and efficiency, the curette should have an edge, as Pozzi says, like that of an unfiled knife-blade. The sharp curette, the curette of Sims, is likely to remove the mucosa in its entirety, and thus give rise to cicatricial tissue, or even to penetrate the uterine wall and enter the peritoneal cavity—dangers that no one of large experience with this instrument, will pronounce chimerical. Emmet even goes so far as to declare that the sharp curette is capable of more harm than any other instrument ever devised by the ingenuity of man.

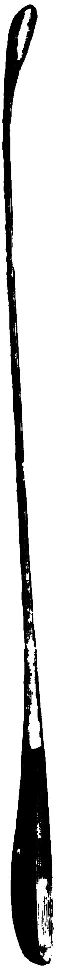
But if, on the one hand, the sharp curette is unsafe, on the other hand, the dull or wire curette is inefficient except by the use of force that makes it even more dangerous than the sharp curette itself. A medium edge, then, an edge neither so sharp as to remove the mucosa *in toto*, nor so dull as to endanger the uterine wall by the force necessary to its efficient use, a watch-spring edge, is most suitable for the uterine curette.

Other things being equal, the fenestrated curette is more likely than the solid one, to remove the mucosa too deeply or to penetrate the uterine wall, for with the former the force is exerted almost wholly on the edge, while with the latter it is distributed more or less over the entire chord. Moreover, an important function of the curette is to remove the debris which it separates, first to inform the operator of its nature and quantity, and second, to assist in establishing an aseptic condition of the uterine cavity.

Whatever the origin, whether in placental remains or in degenerated mucosa, this debris is nearly always infected and often, even before its separation, has been the source of grave symptoms, either local or constitutional. The bowl of the curette, therefore, should be solid, not fenestrated.

It should be somewhat pyriform in outline and only the distal two-thirds of its circumference should present a cutting edge, while the proximal third, being wholly useless, should shade down rapidly to its junction with the shaft.

The shaft should be firm enough not to yield in use, and flexible enough to be easily bent to any desirable angle. It is an error to rely on a flexible shaft to save one from doing harm to the uterus for, to do safe and effective work, the operator must know at every moment, as nearly as possible, just where the cutting edge of the instrument is, and at what angle it is bearing on the uterine tissues.



Author's Curette.

The handle should be of hard rubber to lighten the instrument; and flattened on one surface, that corresponding with the cutting edge of the curette, and rounded on the other, so that it will be instinctively grasped in one way, and in one way only, with the edge of the bowl corresponding with the palmar aspect of the hand.

The course of the irrigating curette easily becomes blocked, is difficult to cleanse, and furnishes ready lodgment for septic matter, while the process of irrigation is likely to distract the attention from curettage—the work really in hand. The plain curette, therefore, is preferable to the irrigating.

In length the curette should be either about 10 or about 13 inches—the latter for the puerperal uterus after the second month and the former for the non-puerperal uterus and for the puerperal uterus before the third month.

In accordance with these views Messrs. Tiemann & Co. several months ago made for me a set of curettes that seem to embody all of the qualities of a perfect instrument. Repeated use of both, in non-puerperal cases, demonstrates their superiority to the curettes I had previously employed.

The limitations of the curette are best observed in the cervix. The persistence of the thick mucous plug and of catarrhal discharge after curettage in chronic catarrh of the cervix and the continued resort to Emmet's and to Martin's operation show conclusively that in this condition the curette is by no means infallible. This was to have been expected. The curette is a sacrificial instrument. Instead of sanifying diseased structures it removes them. But it does not remove them wholly. It leaves behind the *culs-de-sac* of the mucous follicles which dip down into the muscular tissue. This it is that constitutes the strength, but too often, also, the fatal weakness of curettage, its strength because the remaining *culs-de-sac* form the basis for the reproduction of the mucosa; its weakness because these *culs-de-sac*, themselves infected, produce infection of the new mucosa.

In recent cases, cases in which the *vis medicatrix naturæ* has not been exhausted, curettage, with proper adjuncts, offers reasonable hope of cure, but in cases of long standing, cases in which there is profound alteration and infection of the mucosa and even of the muscularis, curettage promises amelioration, marked amelioration even, but, if my observation is to be trusted, amelioration only.

The uterine curette may be used to remove the mucosa, placental and decidual remains, whether *post-partum* or *post-abortum*, uterine polypi, submucous fibroids and malignant growths. The scope of this paper, however, is restricted to the consideration of its use in endometritis and retained placenta.

Carefully done curettage is among the safest of operations; carelessly done it may be the most disastrous. Two elements are imperative—the strictest cleanliness and antisepsis and the utmost thoroughness in curetting. The ease, with which, especially in the puerperal condition, the venous and the lymphatic system of the uterus take on the infective processes, the difficulties of drainage, the proximity of the peritoneum and its continuity with the tubal and uterine mucosa combine to invest with peculiar gravity the existence of a septic condition of the uterine contents. More than almost any other surgical procedure, then, curettage demands the strictest cleanliness and the most rigid antisepsis.

Assuming that these have been enforced, the patient should be put under ether and placed in the semi-prone position. The cervix should be exposed with a Sim's speculum and its anterior lip seized forcibly with the volsellum, the dilator introduced and slowly and carefully expanded until the cervix is thoroughly dilated. Now comes an important point which, I believe, is, too frequently neglected. The cervix should be "thoroughly dilated" for those purposes—diagnosis, curettage, drainage. Immediately after dilatation there should be made a thorough digital exploration of the uterine cavity, a bimanual examination and, if necessary, a recto-abdominal examination of the pelvic organs. In this way we shall obtain information of great value not only as to the present, but also as to the future conduct of the case—information as to the condition of the uterine walls and mucosa, the absence or presence and situation of placental remains, polypi, fibroids, the existence of adhesions and the condition of the adnexa.

These data having been ascertained, the index finger will sometimes be found the safest and most efficient curette—a curette with "brains in it." Retained placenta particularly may be detached and removed in this manner. Curettage itself should be systematically and thoroughly done, beginning at some particular point from which it proceeds continuously over the entire mucosa—including that of the cornua, the internal os and, if necessary, the cervix. It should be continued at every point until the superficial mucosa is removed and the underlying muscularis imparts to the hand through the curette the characteristic grating sensation, which, once recognized, can never be mistaken.

Two conditions, as I have said, are essential to the success of curettage—the strictest cleanliness and antisepsis and the thorough removal of diseased or adventitious tissue, and of placental or decidual remains. In retained placenta considerable difficulty will often be experienced in detaching the adherent portions, but they must all be detached and removed, or the operation were far better not undertaken. A little patience and perseverance in these cases will always be rewarded by ultimate success.

In all cases the debris should be removed as thoroughly as possible with the curette; otherwise it will remain to undergo decomposition and to infect the uterus. Irrigation removes very little of this debris, for, as ordinarily employed, the catheter blocks the cervical canal so that only the smallest particles can pass it.

All of the loosened tissues having been removed the uterus should be thoroughly irrigated with a creolin solution (1:100). If the possibility of infection is entertained the uterine walls should be "scrubbed" with iodized creosote in the following manner: draw into an ordinary hard rubber uterine syringe about 2 drachms of iodized creasote, wrap the distal end of the nozzle with absorbent cotton, introduce it into the uterine cavity, and as the iodine solution is slowly expelled "scrub" the entire uterine wall. Any excess of the medicament should be washed away with creolin solution, with which vaginal antisepsis should be maintained for not less than a week following the operation.

212 J street.

NOTES ON A CASE OF SUSPECTED MULTIPLE SARCOMA OF THE SKIN.

By R. W. Baum, M.D., and D. W. Montgomery, M.D., San Francisco, Cal.

Read before the California Academy of Medicine.

The patient, Mr. C. H——, aged 51 years, by occupation a laborer, was born in Germany. There is very little family history, as patient lost his parents when quite young. He says he has always been well, excepting once, in 1871, when he returned from the Franco-German war, and suffered from a dropsical affection of his entire body. This trouble, however, which was attributed to exposure during the war, was of only short duration, and patient soon recovered under treatment at a hospital in Hamburg. From that time on, he enjoyed good health until about two or three years ago, since which time he has been troubled, off and on, with pains in the region of the stomach and left side, which were usually worse about one and a half hours after meals. For a period of three or four months, there were no pains except on pressure. There never was any vomiting, but sometimes a nauseous feeling, especially when constipated. There is said to have been pain in both lumbar regions, and at such times more or less difficulty in passing urine. All these symptoms seemed to become more severe, so that the patient could not attend to his occupation; he therefore sought relief in the German Hospital in San Francisco in August, 1893.

The physical examination showed a man of about medium hight, fairly well nourished, of a very dull, ashy-colored complexion. On palpation of the abdomen, there is a sensitive point over the upper part of the epigastrium, but no nodular formation or hardness is perceptible. Patient's appearance is decidedly cachectic, and he says that he has lost weight within the last year. Urine is normal. Percussion and auscultation reveal nothing abnormal. Contents of stomach show free hydrochloric acid by color test.

On careful inspection of the body, no abnormal condition of the skin is found, excepting a small protuberance, like a little nodule, about the size of a pea, of a bluish-red color, on the inside of the right thigh.

Although the general appearance of the man suggested some malignant disease, apparently cancer of the stomach, the physical examination did not in any way sustain such a diagnosis.

Patient was put on treatment especially adapted to relieve the gastric symptoms; he was given simple but nutritious diet; bitter tonics, such as condurango, and gentian, etc. He soon began to improve, and even gained a little in weight, so that after four weeks' stay at the hospital, he was allowed to go, and was considered cured, although his complexion still showed the ashy hue.

In October, 1893, fully five weeks after his discharge, patient returned to the hospital with the same symptoms as before, only more pronounced. A careful physical examination again gave the same results: free hydrochloric acid in the stomach contents; urine normal; heart, lungs and liver normal; no enlargement of spleen. In marked contrast with these conditions was the pallor and leaden color of his face.

Whilst making a physical examination, with Dr. Montgomery, there was observed a small bluish-red nodule in the skin of the abdomen, to the right of the navel; also, a very small one below the left clavicle. Both little nodes were adherent to the skin, movable with it, but not adherent to the underlying tissue. Patient had never observed these nodules before and only knew of the one already mentioned, on the right thigh, which he had seen ever since he was a boy, and had considered a mole. Not having noticed the little tumors before, the suspicion was awakened that they were connected with the disease and were of a malignant type.

The large nodule, which patient asserts he has seen since childhood, was partially excised, and, on microscopical examination by Dr. Montgomery, found to be embryonic tissue, *i. e.*, connective tissue with a number of spindle cells.

About four weeks later, the previously partially excised tumor of the thigh was found to have grown to about the size of a brown bean, the one near the navel had also reached about the same size, and there were a number of new tumor-like, bluish-red discolorations, about the size of a lentil, on the back, to the right of the spinal column, near the last ribs.

The tumor on the thigh was totally extirpated and found to be fully encapsulated and imbedded in the skin, not adherent to the underlying tissue; the same conditions were found to prevail in the second tumor on the abdomen, which was also excised. Both tumors showed, on microscopical examination, a decided prevalence of spindle cells, especially in the second tumor, the one of recent origin. The second excision of the first tumor on the thigh showed a much greater predominance of the cellular elements than at the first excision.

Patient has been steadily, although very slowly, losing weight; he still complains of pain in the region of the stomach and under the sternum. Percussion over the entire chest reveals no abnormal dulness. Lately a large number of very slight uncolored protuberances or thickenings in the skin have been observed, too slight to be felt, but plainly visible when lights fall on patient's skin from an angle.

In view of the general symptoms, and especially of the microscopical examination, the diagnosis of multiple sarcoma of the skin, probably secondary to sarcoma of some internal organ, seems justified.

MICROÖRGANISMS AND THEIR RELATIONS TO DISEASE.

By S. M. Mouser, M.D., San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

Half a century ago the physician who would have asserted that disease was an entity would have been indicted by his orthodox brethren for heresy. Within the recollection of many here present, disease was thought to be a perverted physiological action, depending on the failure of some one or more organs of the body to perform their legitimate function; a lack of harmony of function, which was in most cases not well understood. There was a faint suspicion that some undefinable thing, entering the system from without, caused malarial fever; and it was even hinted that it might be a fungus, but the prevailing opinion was that it was caused by gases arising from decaying vegetable matter, producing chemical changes in the blood. Fermentation was supposed to be an important factor in the production of disease, and it was generally admitted that this was a process due entirely to chemical action, until it was proven by Pasteur and others that every fermentation has its special ferment, and that it is a living organism. This was an important epoch in the history of medicine, and physicians began seriously to turn their attention to the proposition that possibly the microbes, which were known to be floating in the air, might figure as the cause of disease.

About the middle of the present century microörganisms were discovered in diseased and dead animals, which led some investigators to suspect that they might be disease-producing. About that time Davaine discovered anthrax in cattle suffering from splenic fever, but its true significance was not known to the profession until 1863, when he demonstrated by cultivations and inoculations that it was beyond doubt the cause of the disease. This gave fresh impetus to the study of bacteriology, and was the dawn of scientific medicine. Since then rapid strides have been made until the cause of most infectious diseases is known and the germs which produce them have been recognized, and proved by cultivation and inoculation to be such. The pathogenic property of this organism being known, scientists turned their attention to its classification, and decided, with a few dissenting authors, that it belonged to the vegetable kingdom.

In 1870 Dr. Beale, of London, wrote a book entitled "Disease Germs," in which he states that the vegetable nature of disease germs has been disproved, but does not say how or by whom. He does not allude to Davaine's discovery, although seven years had intervened between it and his publication. He declares disease germs to be an excess of bioplasm, originally furnished as pabulum for the various tissues of the body, and when the economy has appropriated all that is necessary for its growth the excess becomes a foreign substance, not only unnecessary but deleterious. That it does not die, but remains living matter, which not only interferes with the growth, but has a tendency to destroy that tissue for which it was originally intended as nourishment. He intimates that in some mysterious way these particles of refuse bioplasm may possibly become the germs of special diseases. This was truly a *germ theory*, as he offers no proof to sustain his proposition. We sometimes yet hear about the germ theory, though the accumulation of evidence, backed by experimental research, should have rendered the term obsolete.

The germs of most infectious diseases, as we now understand them from a bacteriological standpoint, consist of microörganisms, known by the general term bacteria. I say *most*, because there are some diseases known to be infectious, the germs of which are not known to bacteriologists. I use the term bacteria in a general sense, not wishing to enter into nice distinctions in nomenclature, as it is not in accordance with the object of this paper.

Although you are all probably familiar with the organisms under consideration, a brief description of some of their sensible properties and natural history may not be amiss. I shall briefly refer to a few with which we are more immediately concerned, in a general way, not intending to deal with individuals, but classes; leaving individual and minute details to some one else, or for a future occasion.

These minute organisms vary in size from $\frac{1}{60000}$ of an inch in diameter to perhaps 20 or more times that size, and in form from perfectly globular to long, thread-like bodies. The round ones are known as cocci; while those having parallel sides, with greater length than breadth, are called bacilli. We have also spiral forms, which are known as spirilla. There are likewise sarcina, which differ from cocci in their arrangement, and in having one side flattened where they lie opposite their fellows. Sarcina always lie in packets or in pairs, and unless they have been separated by force are constantly found in this position. Cocci are found in masses, enveloped in a gelatinous mass of their own production—zoöglea, or in chains—streptococci. Bacilli lie singly, or by joining end to end form long threads—leptothrix.

All of these organisms, as far as we know, are composed of the same material—protoplasm covered by a cell wall. These, as well as higher organisms, are divided into distinct species, but cannot be recognized as such by their morphology alone. Some of them are morphologically so nearly like others that it is impossible to distinguish them except by carefully observing their natural history, in which they may be found to differ very widely. Their macroscopic appearance, when grown on artificial culture media, is usually characteristic, and one of the means of recognition. The form, color, etc., which the colonies assume, being pretty constant with each species.

They vary in their requirements as to the surroundings, moisture, temperature, etc., and also as to food material. Some may become dessicated, and remain so for a long time to revive and grow again when the requisite conditions are restored. They vary in regard to the temperature best suited to their growth, as well as in their thermal death point. Some of them grow well at a temperature as low as 20°, while others require a temperature of 40°. Some survive for an indefinite period when frozen in ice, and thrive and multiply when the requisite temperature is restored.

They differ very materially in the manner of their reproduction. as some simply divide, becoming two individuals, while others are spore-bearing and reproduce themselves in this way. Much more might be said of their sensible properties and life history, but I have already occupied too much of your time on this point. I wish, however, to say a word as to their attenuation. They become attenuated at a temperature somewhat above that necessary for their growth, and by frequent artificial cultivations, and are again restored to their former virulence by being inoculated into and passing through the animal economy. That these organisms are disease producing, and that special kinds produce special diseases, is a fact too well established to require proof, or even mention here.

They are found everywhere. In the food we eat, the water we drink, the air we breath, and the earth we walk upon, and they enter the system in various ways. Those whose habitat is in water, as cholera bacilli, may enter through the stomach, finding lodgment in the alimentary canal. Of course those found on any article of food may enter in the same way, and find the same lodgment. Those floating in the atmosphere enter generally by way of the respiratory organs, finding a resting place in the parenchyma of the lung or air vesicles, whence they pass readily into the circulation. They may be injected directly into the blood vessels, or, coming in contact with the surface denuded of cuticle, are taken up by absorption and enter the system in this way. They may also be injected into the connective tissue beneath the skin, or into the peritoneal cavity. It is quite probable that there are other avenues of access, but those enumerated seem to be the principal ones.

Nature has placed guards at these different avenues, to prevent invasion: the cilia, which are in constant motion in the respiratory organs; the gastric juice in the stomach, which by its chemical action is calculated to destroy them; and the inflammatory condition set up by puncture or abrasion of the skin. In the latter case, a wall is erected to prevent further invasion, the injured point being surrounded by a barrier of lymph and white blood corpuscles. Notwithstanding all of these defenses, many invaders pass the sentinels, and become ensconced in their new abode, and then comes the effort at expulsion or destruction.

The process of expulsion or destruction of microbes after they have entered the system, is called phagocytosis, and the agents by which this process is carried on, are called phagocytes. Most prominent among these are leucocytes, which seem to be the natural defenders of the system against invasion by pathogenic bacteria. They are said, however, to be aided by improvised phagocytes, enlisted from different parts. Splenic cells are said to play an important part in this work, and the fixed cells of the liver and other organs are said, on urgent occasions of need, to be changed into giant cells, with phagocytic tendencies, to aid in the expulsion of the enemy, and to again resume their normal functions as fixed cells when this emergency has passed.

It has been proven that blood serum exerts a powerful influence in the destruction of microbes. It is an established fact that the system is less likely to be affected when microbes are injected directly into the circulation than when injected into the connective tissue. Much speculation has been indulged in as to the particular thing which resists their growth in the body. Mechanical and chemical resistance have been largely alluded to, but it is, I think, quite likely that there is also a peculiar vital resistance which is not yet understood.

Nuttall and others have made some valuable observations relative to the effect of blood serum on their growth, by which it has been ascertained that many of them are destroyed, or fail to grow, when placed in contact with serum of recently drawn blood, but that the serum loses its power to destroy or to retard their growth after a few hours. This would seem as though there had been a vital force at work, and that when vitality had wholly ceased, the serum had no longer phagocytic power.

On examination of the blood of animals suffering with infectious disease, microbes are sometimes found in large numbers within the white blood corpuscles, and it has been questioned whether they had been captured while living, or whether they were gathered up after death for removal. I am inclined to the former opinion.

The animal economy, after having once been invaded by some of the pathogenic bacteria becomes immune, which immunity continues indefinitely, but just how this immunity is brought about is a matter not definitely settled. Some suppose that it is in consequence of a poisonous product of a first attack or inoculation, which is left in the system and is ever ready to repel a fresh attack. Sternberg is inclined to favor this theory, from the fact that serum from an animal rendered immune by inoculation, when injected into one to be inoculated, prevents the growth of the virus, or if injected after inoculation, stops the progress of the disease. There has been much discussion on this subject; and as yet a great deal of difference of opinion exists.

That there are certain conditions of the system necessary to favor the growth of special disease germs is highly probable, as we notice in artificial cultivations that a strict observance of conditions is essential to success. When the vital forces are in full vigor, there is less chance for a successful lodgment of disease germs than when, from any cause, a weakened and depressed condition exists. While the weakened system is more liable to be attacked by infectious disease, there can be no special infectious disease without the special germ. There is a notion prevalent amongst laymen that diphtheria, small-pox, scarlet fever, etc., may be produced by a common cause, a foul sewer for instance. These may all come from one locality, but each specific germ must be there in order to produce each specific disease. This is a matter too well understood to require argument.

Not the least important feature of the application of bacteriological knowledge is its value in diagnosis. Not infrequently we meet with obscure cases, the nature of which may be made clear by microscopic examination, and when the diagnosis is clearly settled it may be of vast importance to the patient, and of great satisfaction to the attendant. It is not only a matter of physical suffering, as sometimes a moral question is involved that may affect the happiness of families. It would not be prudent for a medical man to pronounce positively that his patient has tuberculosis, until the bacillus of tuberculosis is found; nor to declare he had gonorrhea until he had found the gonococcus.

We have much to expect from the bacteriologist in the way of prevention of infectious diseases, not only by causing immunity by inoculations with attenuated virus, but by pointing out the habitat and manner of their invasion of the system. To be forewarned is to be forearmed; so that if we have familiarized ourselves with their natural history and noxious properties, fully understanding their tactics, we are better able to repel their attacks.

It is necessary not only to guard the portals through which they are known to enter, but, as far as possible, to place the system in a condition unfavorable to their existence after having gained admission. I have already alluded to their exacting demands when grown on artificial culture, and we have reason to suppose that they are equally fastidious when ensconced in the living body. Much may be done by making their new quarters distasteful. It is not so easy to do this as one might suppose, but it is an important means of ridding ourselves of their presence.

Of course, disinfectants play an important part in the prevention of infectious diseases, but their application to infected living bodies is not so available.

The antagonism of different species of microbes is receiving the attention of bacteriologists at the present day, with a prospect of beneficial results. We have been advised to fight fire with fire, and orchardists are importing insects to destroy other insects, taking their choice between evils. It has been suggested that microbes would obey the same laws, and trials have been made successfully. Several eminent bacteriologists have been and are making experiments in this direction by inoculating with the streptococcus of erysipelas persons suffering with cancer, and the results are said to be highly satisfactory. Patients suffering with diphtheria and some other infections have been similarly treated, with like results.

In some of these experiments the question has arisen as to whether the remedy might not be worse than the disease? In inoculations with the streptococcus, erysipelas has not always been the result, but even in the cases of failure to produce it, it is said to have had a beneficial effect, so far as the cancerous or other original disease is concerned.

Experiments have been made by inoculating non-pathogenic organisms into the infected animal, and have proved to be entirely satisfactory. Should further experiments fully prove the efficiency of these non-infecting organisms and their entire harmlessness, we will have placed in our hands a powerful weapon with which to combat our enemies.

Reasoning from analogy, we have good ground to believe that these important results have been attained, as we know by experience in laboratory work that when two or more species are planted upon an artificial medium, and upon which either, when in sole occupancy, would thrive well, that one will thrive better than the others, or crowd them out entirely. With all the facts in this war of races before us, we may reasonably expect important results from further investigation.

There are two modes of death in infected animals: one mechanical, the obstruction of the capillary circulation, and the other by a poisonous product of bacteria, called ptomaines, the latter prevailing in a majority of cases.

It was formerly believed that ptomaines were the products of bacteria of decomposition, and were found only in dead and decaying animal matter. This, however, has been proven not to be the case, so that it is now pretty well settled that they may be produced by bacteria within the living body, and that their toxic properties cause the death of the host.

As already stated, there are some infectious diseases, the germs of which are not well known. Klebs, in his study of malarial fever, discovered a bacillus which he claimed to be the cause of the disease, but the researches of other bacteriologists have not confirmed his opinion. Laveran and others have discovered amebiform bodies in the blood of persons suffering with malarial fever, to which they ascribe the disease. They vary in form, some being crescentic, while others are irregular in shape, and are supposed to represent the different types of the disease. They are called plasmodia, and are entirely different in appearance from bacteria.

While they are generally admitted by bacteriologists to be the cause of malarial fever, they have never been proven to be such by the usual tests of cultivation and inoculation. The blood of persons suffering with malarial fever has been inoculated into healthy subjects and has produced the disease, but this can hardly be considered proof positive that these ameboid bodies are responsible for the result. Until pure cultures can be made outside of the body, and then inoculated into the healthy subject, producing the disease, their office in the pathological process can hardly be considered a fixed fact.

Whether these bodies enter the system in their present form, or whether they are evolved from the plasma of the blood, by the influence of something else taken into the system from without, I think is worthy of further investigation. We know that amebæ are abundant in stagnant pools, and that after having been long dessicated, when placed in favorable surroundings, they resume their activity. It is not unreasonable to suppose that in this dessicated condition they may rise on currents of air and enter the system through the respiratory organs. They are usually found in the red blood corpuscles, and not in the leucocytes, which are supposed to be scavengers and defenders of the system against intruders.

These plasmodia correspond to the description given by Beale, in the works above alluded to, of disease germs in general, and were probably known to him, though he does not allude to them as specially connected with malarial fever.

There are a number of diseases which are positively known to be infectious, the germs of which have not yet been recognized, and, although rapid strides have been made in bacteriology within the past quarter of a century, there is still a vast field open to this line of investigation.

705 Bush street.

SERUM OR PHAGOCYTE—WHICH?

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Read before the San Francisco Medico-Chirurgical Society.

The self-limitation of *certain* diseases has been a fact long familiar to us; but never before has the profession so fully recognized the *general* law of self-limitation in disease as at the present time. Not long ago we were content with explaining the problem by the high sounding *vis medicatrix naturæ.* Now, led by the impetus given to scientific research by bacteriological discoveries, our investigators are trying to unravel and to explain the workings of nature, and to make known her methods.

As in all the arts and sciences the final recourse is to the study and imitation of nature, so we in medicine are being led to the study and imitation of nature's methods in the prevention and cure of disease. The barbarian knew no other methods in dealing with problems than a resort to force and subjugation, while civilization teaches that mutual aid and coöperation is the better plan. So we, having tried to fight mysterious force by counter-force—terming our efforts the "cure" of disease—now begin to realize that we shall accomplish more by a careful study of natural methods, trying to imitate, aid and to coöperate with nature in her struggle with unseen foes.

This self-limitation suggests, if it does not prove, the presence in the body of some bactericidal agent or agents. To aid these, and to introduce new agents for a similar purpose, is the aim and hope of the modern therapeutist. The results thus far of experimental investigations warrant continued work in this field, and instil the hope of eventually deducing such methods of treatment as shall revolutionize therapeutics and verify the dream of the idealist—the prevention and cure of disease through internal antisepsis.

It would seem that several paths should lie open to us in prevention and treatment: (1) The partial or complete avoidance or destruction of the cause before its entrance into the body. (2) Such modification of the host as shall make him able to resist virulent parasites by rendering his tissues and fluids unsuitable media for them. (3) Destruction of the virus after its entrance. (4) Destruction of the parasite after its entrance. (5) Neutralizing the action of the poison by the use of physiological antagonists.

How, then, does nature direct her armament? A number of theories have been advanced, all of which concern either the blood and other fluids or the living cells. The leading hypotheses at present in the field are known as the "phagocyte" theory and the "serum" theory.

In the former, which was first advanced by Metschnikoff, in 1883, certain cells possessing the power of ameboid movement are the protectors of the system against parasites, acting by individually surrounding and enclosing the invaders that they destroy. These phagocytes are attracted to microbes (as indeed to all foreign bodies in the tissues), and the frequent presence of the microbe within the phagocyte is given as proof of the latter's destructive power. It has been found, however, that some microbes attract, while others repel the phagocyte, and the more malignant the microbe, the more rarely is it found in the phagocyte. This attraction has been termed "positive chemiotaxis," and the repulsion "negative chemiotaxis."

The chemiotaxis in a given animal is variable, and the phagocytes may be gradually attracted to substances in a mild form, from which they shrink when the latter are in concentrated form. Hence, inoculation of an animal with attenuated virus may change the negative to the positive chemiotaxis, and lead the phagocyte after a time to attack similar microbes, but of a more malignant character should the necessity arise. It is also claimed that the phagocytes prevent bacteria usually present in the lungs, intestines, etc., from entering the blood current, and consequently from attacking the system at large.

It is said that influences which lessen these properties of the phagocytes, increase the susceptibility of the individual to disease, so that organisms which would otherwise be innocuous, enter the general circulation as pathological agents. It has been found that rabbits, which are ordinarily unaffected by anthrax bacilli, yield to that disease, when the non-pathogenic bacillus prodigiosus is injected at the same time. Does the growth or presence of this bacillus supply some needed pabulum for the anthrax bacillus, or does it produce some alteration in the phagocyte?

The phagocyte theory seems a plausible one, but as yet it is little more than a hypothesis, and like every other hypothesis, it has aroused controversy. Those who are at present arrayed against the doctrine of phagocytosis, are the champions of the "serum theory," which regards the fluids of the tissues, especially the blood-serum, as an active agent in repelling the invasion. According to their views, the bactericidal property of the body is due either to certain albuminoids, or to special states of the serum-globulin.

The substances supposed to be endowed with such power, are termed "defense proteids," but no attempt has as yet been made to define their distribution in the tissues. Some also claim the existence of "attenuating proteids" in the serum of animals refractory to certain diseases. Others assert that the serum defends the organism against infection, not so much by its direct action upon the bacteria, as by its indirect action in rendering the tissues unfavorable to the pathogenic agent, by modifying their nutrition. Thus far investigations have been made only with blood-serum, the aqueous humor, pericardial and ascitic fluids, and with the tissues of the spleen, lymphatic glands, the thyroid and thymus, and "defensive proteids" have been found in each of them.

Let us now take a brief survey of some of the experiments made, with a view to ascertaining the bactericidal qualities of the tissue-fluids and the possibility of utilizing such facts in the treatment of disease. These experiments have been made upon the lower animals, and mainly in connection with anthrax, tetanus, and mouse septicemia. The substances used have been serum, either directly from the blood of one of the larger arteries of an immune animal, or pericardial, hydrocele, or ascitic fluid from the same, and lately extracts from the thymus gland, the spleen, and lymph glands have been used. Sometimes attenuated culture-fluids are employed, and again, attempts have been made to isolate the essential antiseptic proteids from the serum and the culture fluids so as to finally employ the alkaloidals themselves, if we may use the term.

Arterial blood has shown more distinctive action than has venous blood; and fresh blood more power than blood which has been withdrawn a short time. The removal of gases from it did not affect the germicidal power of the blood.

Rise of temperature from 100.4° to 104° F., somewhat increased its germicidal power; above 104° it diminished. A general germicidal power of serum has been disputed; and from the present state of our knowledge on the subject it would appear that each species possesses its special and characteristic qualities of serum. Prolonged observation of each species of animals, as to its bearing toward each species of bacteria, will be necessary in order to determine the germicidal quality of its serum.

Some experimentation with drugs has been made; hydrochloric acid had no effect, tartaric acid decreased, quinine decreased, sodium chloride, as well as carbonate of ammonium, slightly increased, phosphate of sodium, sodium carbonate, and potassium carbonate markedly increased, the bacteria-destroying power of the blood, according to one experimentator, who used rabbits affected with anthrax.

The serum of rabbits previously vaccinated against tetanus, destroyed the toxin of tetanus. Guinea-pigs (which are very susceptible to tetanus) were both rendered immune and cured of the disease by the injection of serum from rabbits rendered refractory by inoculation. One cubic centimeter of a filtered culture of the tetanus bacillus, of markedly toxic character, was mixed with serum from a rabbit rendered refractory to tetanus, and the mixture injected into guinea-pigs, rendering them refractory to subsequent injections of the pure filtered culture-fluid.

A thymus gland extract has been recently used. Rabbits affected with tetanus were cured, others rendered immune by injections of this extract mixed with virulent culture-fluids. A culture of cholera spirilli, made on thymus extract, proved almost poisonless. The toxic properties of diphtheria, typhus, and erysipelas cultures were neutralized by similar admixture, and similar injections proved curative and preventive when used on guinea-pigs and white mice.

Serum-therapy has been used with success upon animals for anthrax and mouse-septicemia. Guinea-pigs have been thus cured with rat-serum, and with albuminoids extracted from the spleen of a rat; while rats and mice have received immunity and cure from the use of certain extracted substances termed albumoses.

Quite recently, this line of investigation has been employed in diphtheria and tuberculosis, the serum from pigeons, dogs, goats, and other animals receiving attention, but it is, as yet, too soon to predict the final outcome of such experiments.

At first glance, it would seem as though we had here two antagonistic ideas: the one pertaining to biological cell-action, the other a matter of the chemical composition of serum. But does the one disprove the other? It seems to me that both may be true; and even admitting the correctness of the serum investigations, the phagocyte theory is still tenable.

"Defensive proteids" are acknowledged to be obtainable from the spleen, thymus, and lymph glands, all of which consist of cells, potentially phagocytes. Why are not these proteids the weapons of the phagocytes, and why may they not get into the serum after the death of the phagocytes? Or, even granting this to be erroneous, why is it not probable, in the light of present investigations, that both of these, and perchance, still other as yet undiscovered agencies, are employed in nature's effort to protect and defend?

21 Powell street.

MEMORANDA.

A Case of Supposititious Labor.

About 4 A. M. on December 3d, Mr. P—— called me in great haste, and on our way to his house informed me his wife was in labor, and had been for 24 hours. On the previous night he had summoned the family physician who was still in attendance. Consultation had been suggested because of the delay and a suspicion of mal-presentation. A nurse was in charge, the baby wardrobe was warming before the fire, and there was present every circumstance of the usual lying-in chamber. The physician in attendance briefly outlined the history of our patient: The cessation of menstruation nearly *ten* months previous to date, the gradual enlargement of abdomen and breasts, and, in short, an ordinary gestation in all respects other than time. The lady was about 45, rather stout, and quite healthy in appearance, and years before had had two children. The powerful expulsive efforts suggested advanced labor, and I was informed the waters had escaped hours before. My confrere asked me to examine her. While doing so the anxious husband inquired if the child were "crosswise." Meanwhile I outlined the usual landmarks carefully, and noted a gush of waters at the moment. But my finger was in contact with an undilated os. The cervix uteri was normal in size. The womb was small and movable. The "waters" were being expelled from the bladder. In a word, she was not pregnant, and had not been, a piece of information which the family received with amazement, and which caused me to be looked upon with grave suspicion. However, with the consent of my consultant, I gave her a little chloroform, and presently not only did the pains(?) cease, but the abdomen collapsed. And only then, and not too gratefully, did they accept my decision, and relinquish their purpose of increasing the family forthwith.

OAKLAND, CAL. E. J. BOYES, M.D.

Epithelioma of the Cervix and Ovarian Kystoma (Dermoid) in the Same Patient.[1]

When first seen the patient presented a small polypous growth at the external os; there was also a tumor on the right side of the uterus in the abdominal cavity. Patient was admitted to the German Hospital, and, under ether, the tumor in the abdomen was diagnosed as a fibroid of the uterus. The polypus was removed, the cervix having been split. The mucous membrane of the cervix looked suspicious; a piece was cut out which was diagnosed as epithelioma by Dr. Grazer, and confirmed as such by Dr. D. W. Montgomery. Total extirpation of the uterus through the vagina was decided upon, and was done a few weeks later. When the *cul-de-sac* of Douglas had been opened it was recognized that the tumor on the right side of the uterus was an ovarian tumor, not a fibroid of the uterus. The uterus was removed through the vagina, then the abdomen opened in the linea alba, and the ovarian tumor extirpated. Recovery was uninterrupted. The coincidence of carcinoma and kystoma ovari is not very common; but the condition was also present at a case operated upon at the German Hospital a few weeks ago. A piece excised from the cervix showed carcinomatous degeneration, according to Dr. D. W. Montgomery. There was also a tumor in the left ovarian region. The latter, an intraligamentous ovarian cyst, was removed by Drs. Rethers and Morse during my absence in the east. The operation was difficult, and recovery somewhat interrupted. Upon my return I decided to remove the uterus. The operation was begun through the vagina, but owing to universal adhesions of the body of the uterus on the left side and backward, due to the previous operation, the uterus could not be safely severed from below, and an abdominal incision was resorted to, when the extirpation was successfully accomplished. Recovery was uninterrupted.

San Francisco, Cal. H. KREUTZMANN, M.D.

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[1] These cases were briefly and incorrectly reported in the proceedings of the California Academy of Medicine of November 18, 1898, *vide* MEDICAL TIMES, vol. viii, No 1, p. 45.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and
HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Antiseptic Treatment of Metritis.—DR. LOULIGOUX believes that many of the cases diagnosed as salpingitis, in which severe pain is present, are really lymphangitis. The swollen and congested glands compress the nerves accompanying the uterine artery, causing extreme pelvic tenderness, and sciatic neuralgia, while in salpingitis, pain is confined to the tubal region. The intermittent character of the pain also contra-indicates salpingitis, in which suffering is constant, though varying in intensity. The treatment proper in these cases is first, to open the swollen and inflamed uterine canal; then to assure uterine antisepsis. After securing asepsis by daily injections of sublimate solution (1:1000) for two or three days, introduce a hysterometer, which will indicate the direction of the uterus and the size of the tent required. The tent must be rendered aseptic by soaking in a sublimate solution (1:1000) and its use followed by vaginal irrigation and the application of a dressing of iodoform gauze or absorbent cotton saturated with a solution of sublimate. On the following day a larger tent should be introduced in order to insure easy access to the uterus. Dilatation is usually well borne, and is never followed by a rise in temperature; it nearly always causes an abundant purulent discharge, which necessitates thorough uterine irrigation before continuing treatment. After the uterus is well dilated, introduce a tampon of iodoform gauze, made of strips about 15 inches long and 2 inches wide, saturated with creosote and glycerine (1:3). It is unnecessary, in most cases, to draw down the cervix; traction, when the uterus is already immovable from pelvic cellulitis, excites peritoneal pain and sometimes increases inflammation. The tampon should be removed, at first, every other day, and then every day, and the treatment continued two or three weeks, the patient remaining in bed during that time. This remedy acts in two ways: first, by assuring easy discharge of secretions, and secondly, by applying a strong antiseptic to the walls of the uterus. It is most efficacious in those cases in which fissures are small, and vegetations few. In chronic metritis, with villosities, tortuous glands, or hypertrophied papillæ, it is difficult to reach the entire uterine surface, and although marked improvement, or even temporary recovery may result, the diseased parts, untouched by the antiseptic, give rise in time to new colonies of microbes, which reinfect the entire uterus. These cases require thorough curettage, especially complete at the tubal openings; after which, the fungoid growths are removed by a warm intraüterine injection, the entire surface can be cauterized by the application of the tampon previously described. This method of treatment gives the best results when the tubes are not completely obliterated. If the tubal openings remain closed, we may cure metritis, and lymphangitis, but the tubes, shut off from the uterine cavity, become the seat of independent disease. Laparotomy then remains our only resource.—*Gazette de Gynécologie*, December 1, 1893.

Treatment of Uterine Cysts.—M. J. CHÉRON thus formulates therapeutic indications in uterine cystalgia and the manner in which they should be carried out: (1) Combat painful contractions of the vesical muscle. (2) Relieve the catarrh ordinarily accompanying and increasing cystalgia. (3) Diminish irritability of the genito-spinal center. Belladonna, hyoscyamus, bromides of ammonia, potash and soda are useful in relieving muscular spasm, but this end is more quickly and more surely attained by the use of bromide of camphor, whose antispasmodic action is remarkable, when used according to the following formula: Bromide of camphor, gm. 2, in 20 pills. One pill four times a day. Thuja occidentalis, which is largely eliminated by the urine, soon modifies catarrhal conditions of the urinary passages; 30 or 40 drops a day may be given, in 10-drop doses, with a little rosewater. Irritability of the genito-spinal center can be controlled by a slight revulsion of the lumbo-sacral region, accomplished by small blisters, actual cautery, or prolonged and repeated applications of a liniment composed of: Chloroform, gm. 10; ether, gm. 15; spirits of camphor, gm. 90.—*Bulletin Générale de Therapeutique*, December 15, 1893.

SURGERY.

By T. W. Huntington, B. A., M. D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and

G. F. Shiels, M. D., C. M., F. R. C. S. E., Surgeon Post-Graduate Department University of California, San Francisco.

Surgery of the Ankle-Joint.—An ingenious and interesting operation is reported by Tenier and Hennequin (*Rev. de Chir.*), in which they reproduced the functions of the ankle-joint after the loss of the inferior extremity of the fibula and the absence of the internal malleolus. They conclude that this operation demonstrates the possibility: (1) Of making exclusively from the end of the tibia a joint which allows little to remain wanting in function, and nothing in solidity or regularity. (2) Of preserving entirely the position, the direction, and the function of tendons displaced during the operation, accomplishing this by not opening their sheaths, but removing with them the adjacent periosteum to which they are adherent. (3) Of creating a reärthrosis, so to speak, in its entirety, reproducing with fidelity the normal articulation, and to a certain extent all its movements, except that the tibial surface was made in spongy bone tissue, and in consequence was devoid of cartilage, and the astragalus had lost part of its cartilaginous surface through fibrous degeneration. The patient recovered completely the use of the foot, and could walk with ease, though flexion and extension were slightly limited.—*American Journal of Medical Science*, January, 1894.

A Case of Rupture of Both Quadriceps Extensor Tendons.—S. A., aged 44, was admitted into Sheffield Union Infirmary on March 22, 1893, with the following history: Two days previously, in crossing the street, a man ran against him, causing him to fall. He rose with difficulty, and experienced great pain in his left knee-joint. In attempting to walk he again fell, after which he was unable to move either leg. He was taken home in a wheelbarrow. When admitted, both knees were somewhat distended and slightly bruised. A distinct gap could be felt above the patellæ, which were movable, and could be tilted away from the femora. The detached ends of the tendons were separated by a space of 1½ inches from the patellæ. The lower extremities were fixed on an inclined plane, with strapping arranged so as to bring the patellæ and tendons into apposition. They were left thus for seven weeks, in which time he was allowed to move his legs. Gradually he was assisted to stand and walk. At present he can walk fairly well on level ground, with the aid of a stick? There is still a space between the patellæ and tendons, and he cannot fully extend his knees. After he has endeavored to staighten them, one can, by taking hold of his legs, extend them still further. Both his legs are curved forward and outward, presumably from childhood, though he gives a history of fracture of both tibiæ. He is a stunted, sturdy man, with no history of syphilis. In July, 1892, I attended him for a fracture of the neck of the left humerus and chronic ulcers on both legs, which are now healed. As far as I can find, this is a unique case. In the *Lancet*, Vol. I, 1888, p. 178, a case is recorded of rupture of both tendons within six years of each other. Mr. Joseph Bell, Edinburgh, in his clinical lectures, if I remember rightly, used to relate a case of fracture of both patellæ caused in a similar manner. I may state that the patient refused any operative treatment in the way of suturing the tendons to the bone.—DR. J. LEWIS OWEN, in *British Medical Journal.*

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

The Treatment of Blepharitis Marginatis by Hydrogen Dioxide.—DR. S. C. AYRES recommends hydrogen dioxide in preference to the ointments which are generally used in this condition. The crusts and secretions should be removed by first softening them with tepid water. Then a little cotton is wrapped around a Japanese tooth-pick, which is dipped into the dioxide. The cotton is then wiped over the entire edge of the lid. The characteristic bubbling will follow, and the application is repeated until the bubbling ceases. The ulcers will then present a whitish appearance. With care none comes in contact with the conjunctiva. The treatment should be used daily. Any intelligent person can apply the remedy at home.—*Medical News*, December 23, 1893.

Quinsy and Its Treatment by Early Incision.—DR. J. W. BRANNON concludes a paper on this subject as follows: (1) In quinsy the inflammatory process is usually situated without, and not within the tonsils. (2) If pus forms, it should be evacuated at the earliest possible moment. (3) Unless there are signs of pointing elsewhere, the incision should be made through the soft palate backward. (4) If the tension of the parts is very great, the incision is indicated; even though pus has not formed. (5) If ordinary surgical care is exercised, there is no danger of wounding the internal carotid artery. (6) In case of deep-seated inflammation, in which pus comes to the surface slowly, erosion of the arteries in the neighborhood may take place. In such case, therefore, we must be ready to deal with arterial hemorrhage at the moment the abscess discharges into the pharynx.—*Medical Record*, October 28, 1893.

Strong Solutions of Hydrogen Peroxide in the Treatment of Diphtheria.—DR. F. H. WILLIAMS, in an article on "Diphtheria and Other Membranous Throat Affections," recommends the stronger solutions of peroxide in the treatment of these diseases. The solutions usually sold have a strength of 7.5 to 10 volumes or less. These strengths are not active germicides. Solutions of a strength of from 25 to 50 volumes are efficient germicides and have the quality of breaking up and disintegrating certain portions of the diphtheritic membrane without injury to the healthy tissues. Solutions of the desired strengths cannot be obtained in market, but can be made by evaporation of a 10-volume solution in a shallow, open dish, over a water bath, to ½ or ⅕ of its bulk, which would make a 25 and 50-volume solution, respectively. The 25-volume solution may generally be applied every 4 hours during the night and more often during the day, by means of a spray. A few drops of the 50-volume solution to the membrane, with a swab, until the membrane is gone or much diminished.—*American Journal of Medical Sciences*, November, 1893.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M. D., Sacramento, Cal.

Syphilis as an Infectious Disease.—DR. H. J. KLOTZ, in a paper on this subject (*Journal Cutaneous and Genito-urinary Diseases*), reaches the following conclusions: Syphilis is caused by a microörganism similar to those of the acute exanthemata. Primary and secondary local manifestations are due to the direct influence of this parasite. Its presence in these lesions is proved by their contagiousness. The general symptoms accompanying the stages and immunity are the result of the action of toxines. The microörganisms, under the influence of their own chemical products, or under the influence of treatment, or in consequence of their own innate character, are either eliminated, or become extinct, or undergo some modification, or produce a new kind or species of microorganism. This secondary parasite, which is similar to the bacillus of tuberculosis, can indefinitely remain in the organism, in a dormant condition, until called into activity by some accidental irritation. Accidental irritation produces the tertiary (gummatous) manifestations; but not the visceral affections, like tabes, general paralysis, etc., which are the result of intoxication with the toxines of the primary parasite. The secondary microörganism is inoculable, like the bacillus tuberculosis, and produces lesions identical with the tertiary syphilis, but not primary syphilis. Tertiary syphilitic manifestations may, therefore, be due to direct inoculation without the necessity of a primary or a secondary stage.—*Medical Record.*

DR. R. W. TAYLOR, in opening the discussion, carefully reviewed the conclusions drawn by Dr. Klotz in his paper. As regards the statement made by the author, that syphilis is caused by a microörganism similar to those of the acute exanthemata, Dr. Taylor said that our present knowledge on this point is only based on presumptive or analogical evidence. We do not know positively that the disease is caused by a microörganism. Lustgarten and others, by various methods of staining, have found certain bacilli in syphilis; the results of these bacteriological investigations differ from each other, and experiments have not been followed up by culture-growths or inoculation, therefore do not come up to the requirements of Koch as to the identity of a given parasite. The protoplasmic changes which take place in syphilis are the reproduction, *ad infinitum*, of the cells in the original lesion. That the general symptoms accompanying the disease and the impairment of nutrition are due to the toxines secreted by these cells, as stated in Dr. Klotz's paper, is based on the theory that there is a primary microörganism in syphilis, which, under the influence of its own chemical products, or of treatment, or in consequence of its natural innate character, is eliminated, or undergoes some modification, or evolves a new kind of species of microörganism, and that this secondary parasite produces the tertiary gummatous manifestations—all this must be regarded as pure conjecture. We are not in a position to-day to generalize upon the microbic action of syphilis. The data upon which the conclusions are based are not satisfactory; the cases are not conclusive. Clinical observation rather goes to show that the tertiary manifestations of syphilis are the result of a low grade of inflammatory process that has been left over from the second stage. Because we observe tertiary lesions in patients from whom we can get no history of any previous specific manifestations does not necessarily imply that those lesions are the result of direct inoculation. The primary and secondary symptoms are often very slight. The syphilitic roseola may be so faint that it readily escaped detection. This is also true of the papular syphilide. The initial lesion of the disease may pass undiagnosed. It may be on the tonsil, giving rise to very little trouble, or it may be a small herpetic vesicle on the lip. The chancre may simply appear to be a slight excoriation of the mucous membrane.—*Journal Cutaneous and Genito-Urinary Diseases*, January, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

The Moderate Use of Alcohol.—The unique position of the medical man in regard to the question of alcohol, imposes upon him a high responsibility which has been fully recognized, and the one consistent note in the advice given by all the prominent men in our profession has been moderation. In all intelligent society not only has drunkenness decreased, but the consumption of strong wines has diminished, and the restriction of the use of wine to mealtimes has become more common. These real gains are sadly inadequate, in the judgment of the extreme teetotaler, who would like an unmitigated curse to be pronounced on alcohol, and its use to be absolutely interdicted. When a medical man, with the judicial impartiality and scientific accuracy of his profession, ventures to say a word in favor of the agent, the teetotaler is apt to lose self-control and denounce the man, who is as sincerely convinced of the evils of alcoholism as he is, but differs from him as to the way in which they should be met. Such was the experience of SIR DYCE DUCKWORTH, who was greeted with "slight applause, mingled with hissing," at a temperance convention which he had addressed on the physiological effects of alcohol on the human organism. The following are summarized conclusions of the speech, which provoked expressions of disapproval: (1) That it had not been proved that the moderate use of alcohol was hurtful to the inhabitants of Europe and was necessarily prejudicial to civilized nations. (2) That the most enlightened nations had, as a rule, made use of alcoholic liquors. (3) That there existed no enlightened testimony to show that the moderate and simultaneous use of alcohol and of sound food could injure the organs of the human body; that, on the contrary, there was ample proof in support of the assertion that such a use was beneficial and that the legitimate and rational use of a thing by no means justifies its abuse. (4) That for many people complete and continual abstinence from alcohol was not at all to be recommended, and that it was recognized that such a course of conduct, employed as an exemplary measure, had never, with any people, succeeded in bringing about the disappearance of intemperance. (5) That the majority of the posterity of drunkards and of persons of an ill-balanced, nervous system, would do well to abstain altogether from alcohol; or at least before partaking of it to consult a competent and experienced physician. (6) That the use of impure and adulterated alcoholic drinks is attended with many consequences more or less disastrous, and that the extreme physiological limit which the individual constitution can support ought rarely to be reached, most certainly not passed. (7) That the young should be instructed, as part of their education, to recognize the proper and legitimate use of alcohol, and to moderate and subjugate their appetites.—*Lancet.*

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M. D., Professor of Pathology, Cooper Medical College, San Francisco.

Contagiousness and Inoculability of Cancer.—DUPLAY and CAZIN (*Semaine Médicale*) sum up all that is so far known respecting the transmissibility of cancer. They consider the question of the parasitic nature of cancer as still "without sufficient facts to support it." They maintain that of all the modes of transmission of cancer, there is only one respecting which everybody is agreed, viz: that which consists of what is called auto-inoculability. Numerous cases are on record where patients, already the subjects of cancer, have been inoculated in some sound part of the body with fragments of the same cancer. Transplantation experiments with cancerous fragments to the bodies of healthy individuals, having no predisposition to malignant growths, are negative. This is also true of experiments on animals. The essential condition of the development of malignant neoplasms consists in a special predisposition, certainly hereditary, which we cannot at present define. The comparison of cancer to tubercle is not tenable; inoculations with tubercular products are, as a rule, positive, whereas with cancerous products the results are negative. The authors conclude that while nothing at the present time warrants us in believing in the direct contagiousness of cancer, we are none the less convinced of its infectious nature, dependent on a process of which we are still completely ignorant. We have no right to speak of cancerous patients as if they were possible sources of infection.—*Boston Medical and Surgical Journal.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M. D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Admissibility of Expert Testimony not Based on Personal Experience.—In a recent decision of the Supreme Judicial Court of Massachusetts, in the case of Finnigan v. Fall River Gas Works Co., it is said: "Although it might not be admissible merely to repeat what a witness had read in a book not itself admissible, still, when one who is competent on the general subject accepts from his reading as probably true a matter of detail which he has not verified, the fact gains an authority which it would not have had from the printed page alone, and subject, perhaps, to the exercise of some discretion, may be admitted." The action was against a gas company to recover for the death, by inhaling gas, of an employe of a city water board while in the gas company's cellar for the purpose of reading the water meter, pursuant to his duties. One of the doctors summoned as witnesses in the case testified that the deceased had a period of conscious suffering before death. The doctor admitted not having had any experience of this kind of asphyxiation personally or with patients; his general competency as expert was, however, not questioned. The court therefore said, that it could see no sufficient ground for saying that the testimony admitted in the case could be treated as furnishing no evidence of the fact.—*Medical News*, October 7, 1893.

FORMULÆ.

By Geo. B. Somers, M. D., San Francisco, Cal.

Erysipelas.—The following are several methods of treating this disease:

I. Juhel Renay employs:

Gutta percha	ʒ vi
Chloroform	ʒ vi
Ichthyol	ʒ viii

The erysipelatous spot is surrounded with this syrupy mixture, then it is covered with an ointment composed of equal parts of vaseline and ichthyol.

II. Tichhorst Koenig and Nolée have employed:

Carbolic acid	ʒ ss
Spirits of turpentine	*ad* ℥ i

Paint the affected parts every two hours.

III. Rothe covers the affected parts with an ointment made as follows:

Creolin	ʒ ss
Prepared chalk	
Lard	āā ℥ss
Essence of peppermint	gtt xl

The patient feels an agreeable sensation of coolness and the results are excellent.—*Union Médicale.*

Diabetes.—HARLEY states that croton chloral often produces surprising results. A good formula is as follows:

Croton chloral ....gr. ½
Opium ....gr. i
Ext. of Barb. aloes.......gr. ⅛
Ext. of gentian...........gr. iss

S.—For one pill. One to be taken three times a day.—*British Medical Journal.*

Hemorrhoids. — In recent cases MUNDÉ recommends:

Burgundy pitch ....gr. v-x
Extract of opium ....gr. ½-i

Make into a suppository.

S.—Use at bedtime and again after the bowels have moved in the morning.—*Northwestern Lancet.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for December.—The deaths registered in 90 town districts of the State, during the month of December, in a population of 814,739, correspond to an annual rate of 17.26 a thousand, the total mortality having been 1,105. 87 deaths were due to zymotic diseases, giving an annual rate of 1.27 a thousand. Of these, 24 were due to diphtheria, 6 to cholera infantum, 24 to typhoid fever, 10 to diarrhea and dysentery, 6 to cerebro-spinal fever, 5 to whooping cough, 4 to croup, 4 to intermittent and remittent fevers, 4 to scarlet fever, 0 to measles, and 0 to small-pox. 330 deaths resulted from diseases of the respiratory organs, giving an annual rate of 5.40 a thousand. Of these, 161 were due to consumption, 112 to pneumonia, 46 to bronchitis, and 11 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.28 and 1.56, respectively. 96 deaths resulted from diseases of the heart, 13 from alcoholism, 5 from erysipelas, 30 from cancer, and 479 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 575,400, was 17.16. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Alameda.

METEOROLOGY.

Summary for December.—*Temperature.*—The normal temperature of the State for December is 53°, the mean for December, 1893, was 50°; a departure from the normal of -3°. The highest monthly mean was 66°, at Salton, in the desert regions of San Diego county, 263 feet below sea level; the lowest, 31° at Summit, in the mountain regions of Placer county, 7,017 feet above sea level. The maximum temperature was 94°, at Downey on the 2d; the minimum, zero, at Boca, Nevada county, (5,531 feet above sea level), on the 30th. The greatest monthly range was 61°, at Tehachapi; the least, 20°, at Sutter Creek. The absolute range of temperature for the State is 94°.

Rainfall.—The normal precipitation for the State for December is 4.42 inches; the average for December, 1893, was 7.24 inches; a departure from the normal of +2.82 inches. The greatest monthly precipitation was 10.81 inches, at the Cresent City light house; the least, a trace or sprinkle, at Indio, Long Beach and Salton.

Wind.—The prevailing direction of wind was southerly.

Unusual Features.—The unusual meteorological feature of the month was the continuation of the abnormally cool weather as compared with averages for December and for the year, making the month of December and the entire year 1893 several degrees cooler in the average temperature than are the normal conditions of the month and year as deduced from a 40 years' record.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for December, 1893.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No. of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn.........Cal.	54.0	79.0	35.0	-----	-----	-----	---	3.88	-----	---	---	---	S.E.	Southern Pacific Company.
Berkeley......... "	49.0	66.0	34.0	55.0	44.0	11.0	11	2.62	85.0	12	2	17	E.	Obs. University of California.
Colfax.......... "	48.0	80.0	28.0	-----	-----	-----	---	4.88	-----	---	---	---	N.E.	Southern Pacific Company.
Eureka.......... "	47.0	61.0	34.0	53.0	42.0	11.0	9	6.69	94.0	7	11	13	S.E.	Weather Bureau Dept. Agr.
Fresno.......... "	48.0	69.0	30.0	58.0	39.0	19.0	8	1.40	78.0	3	14	14	N.W.	" " "
Keeler.......... "	45.0	72.0	23.0	54.0	35.0	19.0	3	0.78	46.0	15	10	6	S.E.	" " "
Los Angeles.... "	58.0	88.0	37.0	69.0	47.0	22.0	7	3.65	63.0	16	10	5	N.E.	" " "
Monterey....... "	50.0	70.0	28.0	-----	-----	-----	---	1.87	-----	---	---	---	S.	Southern Pacific Company.
Napa.......... "	52.0	79.0	31.0	59.0	44.0	15.0	7	1.86	80.0	12	4	15	S.	Station Napa Insane Asylum.
Oakland......... "	51.0	67.0	36.0	57.0	46.0	11.0	6	2.57	96.0	13	7	11	S.E. N.W.	Chabot Observatory.
Paso Robles.... "	48.0	71.0	25.0	-----	-----	-----	---	2.38	-----	---	---	---	N.	Southern Pacific Company.
Red Bluff....... "	50.0	76.0	32.0	58.0	42.0	16.0	10	2.64	80.0	14	10	7	N.W.	Weather Bureau Dept. Agr.
Sacramento.... "	49.0	69.0	28.0	56.0	41.0	15.0	6	1.76	84.0	14	6	11	S.E.	" " "
San Bernardino "	52.0	80.0	30.0	65.0	39.0	26.0	6	2.28	74.0	19	7	5	W.	A. K. Johnson, M. D
San Diego....... "	57.0	82.0	38.0	69.0	48.0	21.0	6	1.91	74.0	19	5	7	N.E	Weather Bureau Dept. Agr.
San Francisco.. "	52.0	72.0	37.0	57.0	48.0	9.0	8	2.25	81.0	12	4	15	N.W.	" " "
Santa Barbara.. "	58.0	84.0	38.0	68.0	48.0	20.0	5	2.94	64.0	20	6	5	N.W.	Hugh D. Vail.
Santa Cruz...... "	54.0	78.0	33.0	64.0	44.0	20.0	7	1.80	-----	13	8	10	N.W.	W. R. Springer.
Yuma..........A. T.	58.0	83.0	34.0	72.0	44.0	28.0	3	·0.26	46.0	18	11	2	N.	Weather Bureau Dept. Agr.

T. means a trace of rain. Blank (---) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: FEBRUARY, 1894.

THE MIDWINTER FAIR.

When an invitation was extended, at Milwaukee, to the American Medical Association to meet in San Francisco in 1894, it was not known that the Midwinter Fair would be an accomplished fact. Vague rumors had been heard that such a project was being discussed, and exhibitors at Jackson Park would greet the visitor from the Golden State with the incredulous remark: "You are the people who want to bring the World's Fair to California." At that time no guarantee fund had been raised, nor had exhibits been secured, and the enterprise, at Chicago at least, had met with general ridicule. The foreign exhibitors had but vague ideas of California, and beyond the fact that it was "a few thousand miles" further west, the Land of the Setting Sun was practically a *terra incognita*, but very far west to those who had already come so far. Even the natives of the Eastern and Middle States were as a whole not much better informed than were the representatives of the medical profession from those sections when the project of a meeting in San Francisco was first broached at Milwaukee. The American Medical Association, however, finally decided to make this voyage of exploration into the unknown land, and took this resolution with an enthusiasm that goes a long way to assure the success of the forty-fifth annual meeting. In like manner the Midwinter Fair ceased to be an object of ridicule, and having reached the dignity of an accomplished fact, it soon became an enthusiastic project.

The credit of originating the scheme of an exhibition of the best amongst the foreign exhibits at Chicago, with the addition of displays and special features that would fully represent California, seems to rest with MR. M. H. DE YOUNG, the proprietor of the San Francisco *Chronicle*. MR. DE YOUNG was the representative of California on the National Commission, and, observing the notice that had been attracted to the United States in consequence of the Fair at Chicago, he conceived the idea of obtaining recognition for California in the same way, though of course on a much smaller scale. As showing the climatic advantages of the State it was determined to hold the Fair in "Midwinter," at a time when such a project would be impossible in eastern cities. Except in the high Sierras, California has no winter, as the term is generally employed. During the winter months at Jackson Park when men were employed to shovel snow from the roofs of the buildings that they might not be crushed in, Golden Gate Park was green and beautiful with delicate plants and flowers, blooming, untouched by frost. The selection of this date also made it possible for intending exhibitors to move their goods from Chicago direct to San Francisco without the increased expense of a tedious waiting.

To inaugurate an enterprise of the magnitude of the Midwinter Fair was no inconsiderable task, and opposition, more than encouragement, was freely encountered. At this time the financial panic, that seized the country during the summer and fall of '93, was beginning to be felt, and moneyed men were apprehensive of further disasters. As time passed, the outlook for a business revival was even less encouraging; yet, in the face of these most unfortunate conditions, subscriptions were obtained, funds assured, and on the 24th of August, 1893, the first shovelful of earth was turned on the site of the exposition in Golden Gate Park. This was in what is known as Concert Valley, and, as originally outlined, it was to occupy about 60 acres. Construction was commenced and pushed with unprecedented rapidity. The elements offering no opposition such as was experienced at Chicago, the work could, therefore, be pushed uninterruptedly. Exhibitors and concessionaires multiplied with astonishing rapidity, and it soon became apparent that the original plan of the Fair would be altogether too small. The grounds were extended, the buildings enlarged and new ones added until, at the formal opening of the exposition, on January 27, 1894, it covered 200 acres of ground and included 76 buildings.

Of these structures six are the main buildings of the exposition, viz: Manufactures and Liberal Arts, the largest; Mechanical Arts, the next in size; Horticulture and Agriculture, a picturesque structure in the style of the old Spanish missions; Fine Arts and Decorative Arts; Festival Hall and the Administration Building. Next in importance come the State and county buildings, many of which are very pretentious structures. Finally, there are the concessionaires, our "Midway Plaisance," not confined, as in Chicago, to one locality, but scattered in picturesque diversity about the grounds. Amongst these are many features, interesting, amusing, and educative, that rightly claim more than passing notice. A very brief stay at the great World's Fair was sufficient to convince the intelligent visitor, that to see all the White City contained, and to see it thoroughly, would take months of hard work. The traveler who mapped out his plan of campaign in advance, and with the aid of guide book and map, determined what he should see, saw most and saw it most profitably. In the vastness of space and in the immensity of material was confusion, mental and visual, so that things seen, failed to make a mental impression. These facts are the greatest arguments in favor of the success and of the real value of this Midwinter Fair. Here it has been sought to select, and by careful discrimination, to bring together only the best and choicest of all that was available. The foreign exhibits are amongst the best, while personal and sectional rivalry impels each section to do its very best. The visitor will therefore find, not only an international exposition, but an exposition that is typical of the Pacific coast and illustrative of all California. Here, in a few days, can be learned facts and details regarding every industry and section in the State, that would require weeks of hard work and travel to accumulate.

Finally, local pride demands that a word should be said for the grounds in which the Fair is located. Not for the landscape gardening that is to rival or to surpass the royal gardens of the old world, but for the Park itself, with its variety of hill and valley and mountain, its evergreen verdure, its vistas and prospects, by land and water, the magnificent bay with its Golden Gate, and on its western borders the grand Pacific Ocean. The Midwinter Fair will remain open until the first of July, and will, therefore, be at its greatest perfection when the American Medical Association visits San Francisco. It offers no small inducement to those who may be hesitating to undertake the journey. It has caused reductions in local and transcontinental rates that have never before been presented, and therefore places within the reach of many, a trip to California under exceptionally favorable circumstances.

THE ANTI-CIGARETTE MOVEMENT IN SAN FRANCISCO.

Considerable attention has been recently directed toward the wide spread evil of cigarette smoking among minors. A movement has been started in San Francisco with the object of inducing boys to sign a pledge to abstain from cigarette-smoking until 21 years of age. Many school children have signed this pledge, and the daily papers have taken pains to publish the names of all those who have signed. They have further devoted considerable space to interviews with various persons on the evils of the habit,

The Superintendent of Schools, MR. JOHN SWETT, is quoted as saying: "You have no idea how many girls smoke. It is a fact, I assure you, though you might not think it possible." Many tobacco dealers have expressed themselves in sympathy with the cause, as they say there is no profit in cigarettes, and that the sale of cigars would be increased were cigarettes unobtainable. A number of arrests of cigar men for selling cigarettes to minors have been made with the intention of testing the law on this subject.

The Board of Education has appointed a committee, composed of DR. CLINTON, J. H. CULVER, and J. H. ROSEWALD, for the purpose of investigating the subject and proposing means for suppressing the evil. The following suggestions were made:

First—In our opinion the most radical and efficient way to stop the pernicious habit is by legislation, and we would, therefore, suggest that the Board of Supervisors be requested to pass an ordinance imposing a license of $25 per quarter upon all persons engaged in selling cigarettes.

Second—That the medical fraternity of the city and county of San Francisco be requested to affix their signatures to a document which shall explain in detail the physical evils that result from cigarette-smoking, and that the document be circulated in all the schools of the city.

Third—That the clergy of all the denominations make cigarette-smoking the subject of their sermons on a certain day, to be selected by themselves.

The *Examiner* has had an analysis made by THOMAS PRICE & SON, of several brands of cigarettes. A sample of the analysis is as follows: "We find this sample to contain, in addition to nicotine and the usual constituents of tobacco, chloride of ammonium, niter, and a large quantity of woody fiber other than that belonging to tobacco. It also contains considerable of a soft, pithy material, which strongly resembles the pith or root of some plant other than the tobacco plant. The percentage and character of the ash found were such as to show that the sample is not a pure tobacco."

NOTES.

The National Druggist.

This well known and reliable journal, from whose pages we have often quoted, has recently undergone some changes. It has, for many years, been edited by Dr. Frank L. James, of the *St. Louis Medical and Surgical Journal*, "the oldest monthly medical journal in the United States." Dr. James has recently purchased the *National Druggist*, and therefore becomes both editor and proprietor. The journal, which has been reduced to a more manageable form, will hereafter appear on the first of each month, instead of twice a month, as in the past.

California Northern District Medical Society.

The semi-annual meeting of this Society will be held at Woodland, on Tuesday, March 13. Dr. H. D. Lawhead, the Chairman of the Committee of Arrangements, was a guest of the Sacramento Society at its last meeting, and extended a hearty invitation to all its members to participate. He stated that the local profession was already at work, and that the Secretary had assured him that there would be a good attendance and an abundance of material. This Society is rapidly growing in numbers and is extending its territory and bids fair to be a most important factor in our professional organization.

The Medical Society of the State of California.

The Committee of Arrangements of the State Medical Society has issued its preliminary circular directing the attention of the profession to the fact that the annual meeting will be held in San Jose, April 17, 18, and 19. This circular has been sent to every physician in the State, and has been accompanied by the circular of the Committee of Arrangements of the American Medical Association, and blank applications for membership in the National Association. The visit of the Association to this coast invests the meeting of the State Society with special interest, and there will no doubt be a large attendance. The President, Dr. Kenyon, is an active worker, and may be relied upon to do all in his power to bring about a successful issue.

An Alumni Association for the University of California.

At the reception banquet tendered the class of '93 by the faculty of the Medical Department of the University, the subject of alumni reörganization was enthusiastically discussed, and a committee was appointed to call a meeting of all the graduates, to reconstruct the constitution and reorganize the Association, so as to render it a body of some influence in the community and to make of it a powerful ally of the college. Announcement cards are shortly to be mailed, and it is hoped that every alumnus within touch will be present. There are to be no initiation fees and no assessments. Alumni who have changed their addresses are requested to immediately notify Dr. Edward von Adelung, 836 Sutter street, San Francisco, that they may receive announcements.

The Recent Suicide at Bankshire Place.

The following are the facts of an unfortunate suicide that recently occurred at Bankshire Place, Dr. Whitwell's private asylum, near San Mateo. The subject, a woman over 50 years of age, was chronically insane, type melancholia, with suicidal tendencies and violence. She had been under the doctor's care for the past year, and, although showing physical improvement, there was no material mental change. She talked often of suicide, and said she would certainly hang herself. She showed at times a tendency to violence toward the other patients, and was generally destructive; for these reasons it was often necessary to place her under restraint. This consisted of a canvas jacket, laced behind; the sleeves were long and fastened behind. In or out of restraint she usually sat on the porch, and was under the almost constant supervision of one or two attendants. On the afternoon of the accident she had been placed in restraint, and had been seen within ten minutes. One of the rooms of the hospital opens upon the porch; she went into this, managed to get out of the restraint jacket, took the canvas lacing and put it round her neck. She then, evidently, climbed upon a trunk standing under the iron window guard, and, after tying the other end of the lacing to this, she jumped off. She must have been found almost immediately, but too late to be restored, even by the application of a strong faradic current and artificial respiration. The heart had ceased beating. At the time of the occurrence another patient was being fed, and was making much noise. This prevented the attendant from hearing any unusual noise in the other room. A patient, who is usually very alert if anything unusual is occurring, was sitting just under the window outside, she also failed to hear any suspicious noise. Last April a similar attempt was made by the same patient, but she was discovered in time and quickly brought to. Even under the most careful management distressing accidents of this kind will occur. In the present case it does not appear that anyone was to blame, or that the fatality could have been prevented.

Enterprise, Journalistic and Professional.

Under this heading the *Medical News* discusses the custom, quite common nowadays in certain parts of the country, for the daily newspaper to publish "a special edition largely devoted to biographic and eulogistic notices of 'successful doctors.' The details of the successful careers are blazoned with liberal colors, the office hours, specialties, telephone numbers, etc., following in each case. The fellow who pays the most and furnishes the most glowing and particularized accounts of himself, and who orders the greatest number of hundreds of extra and marked copies for distribution to his *clientele*, is, of course, he that takes the cake. It is mortifying to find certain names in these lists of dishonor." The *Medical News* speaks plainly, but fairly, for this evil seems destined to increase. As Dr. D. W. Montgomery, when President of the San Francisco County Medical Society, well said, it is difficult to see of what possible interest it can be to the public to learn the petty details of the early life and past history of the average physician, nor can there be much credit derived from the vile caricature that often appears as the portrait of the distinguished subject of the sketch. As for his professional career and the wonders he has accomplished, it is even here not easy to see the benefit to be obtained from this kind of publicity. The more intelligent and better-paying portion of the public recognizes this as the method of the quack, and, while perfectly willing to be victimized at times, when something more than ordinary is offered, and at others to be swayed by the influence of occult methods, the physician who repudiates the fellowship of the quack, while adopting his methods, will invariably be looked upon with suspicion. It is quite common in these matters to blame the newspapers, and it is equally wrong to do so. With few exceptions, the modern daily paper is run "for revenue only," and not on principle. Principles are troublesome and they do not pay, so says the "business manager," and he virtually controls the paper, for does he not pay the bills and find therefor the wherewithal? It is in dull times that the keen and active business manager "digs up" these schemes, and they can usually be made quite profitable. We can assure the *Medical News* that this class of business is not flourishing in the far west. In occasional and flagrant cases it has been promptly and speedily suppressed. The action of the San Francisco County Medical Society, not long since, was sharp and decisive, and will serve as a precedent for other bodies that might be more weak-kneed in the protection of their good names.

AMERICAN MEDICAL ASSOCIATION.

Membership in the American Medical Association.—"This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues and subscription for the *Journal.* Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly *Journal* of the Association will be forwarded regularly."

Application Blanks for Membership.—On advertising page xxvii we print a convenient form of application blank that is being circulated by the Association *Journal,* Any physician desirous of joining the Association can cut out this blank, and, having properly filled it, can mail same with his subscription to the Treasurer. As many physicians seem to be waiting for these blanks before joining the Association, it is pertinent to remark that the blank is not a necessity but merely a convenience. The essential is a certificate signed by the President and Secretary of a State or local Medical Society, and this, accompanied by $5, will be duly honored by the Treasurer. Dr. Kerr, the Secretary of the Medical Society of the State of California, has announced that the circulars of his Committee of Arrangements will on this occasion be mailed to every physician in the State, and will be accompanied by blank applications for membership in the Association. Meanwhile our readers will find each month the regular application form in our advertising columns, and we shall be at all times ready to afford any information in these matters.

Circular of the Committee of Arrangements.—The following circular letter has been issued by the Committee of Arrangements, and will be sent to all physicians on the Pacific coast that it is possible to reach:

Dear Doctor: The American Medical Association will meet in San Francisco, June 5, 6, 7, and 8, 1894. The Association consists of delegates and members. Each State and Local Society in affiliation with the American Medical Association is entitled to send one delegate for every ten members or fraction thereof. Any member of such Societies, in good standing, is eligible to membership in the Association, without attending a meeting, on presentation of a certificate of membership in the affiliated Society, signed by its President and Secretary, accompanied by $5.00 annual dues. This entitles him to receive the *Journal* of the Association. It will advance the interests of the profession on the Pacific coast, and will be a fitting evidence of our appreciation of the National Association, if we have a large representation at the meeting, and a larger accession to the membership. United effort will accomplish this, and will assure success. We therefore urge every physician who is not a member of a State or Local Society, to become enrolled as such. If, on account of distance or other sufficient reason, it is impracticable to join an existing Society, it is desirable that he unite with neighboring physicians to form a Local or District Society that will obtain recognition from the State Society where one exists. It will facilitate the work of this committee if you will favor us with the name of your Local or District Society, its membership, and the names of its President and Secretary, together with the names of eligible non-members in your vicinity. A blank application for membership in the American Medical Association is inclosed, which may be filled out and forwarded to R. J. Dunglison, Treasurer, L. B. 1274, Philadelphia, or to this office, with an additional ten cents to pay money order, when we will gladly attend to it. Membership is a prerequisite to entitle one to the privilege of reading a paper in the meeting. Our Midwinter Fair (January to July) is assuming such proportions as will present additional inducements to visit San Francisco, and our hotel and railroad managers are supplementing these by assurances of marked reductions to members of the American Medical Association. We hope the profession on the Pacific coast will turn out *en masse* and give the Association a royal welcome.

R. H. PLUMMER, Chairman.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, December 19, 1893.

The President, F. L. ATKINSON, M.D., in the Chair.

New Members.—J. NELSON, M.D., W. I. TERRY, M.D., were duly elected members of the Society. T. A. SNIDER, M.D., a former member of the Society, was reëlected to membership.

California Northern District Medical Society.—A communication was received from the Secretary of the California Northern District Medical Society, inclosing a formal resolution of thanks extended to the Sacramento Society for its courtesy and hospitality to the visiting members.

DR. J. H. PARKINSON, Chairman of the Committee of Arrangements, presented his report, showing that the subscriptions received toward the entertainment fund had been sufficient to defray all expenses and to permit of the return of a dividend of nearly 50 per cent.

DR. W. E. BRIGGS read a paper on "A Case of Severe Hemorrhage Following Operation for Adenoid Vegetations" [to be published]. The hemorrhage was for a time of a most alarming character, and after the anterior and posterior nares had been securely plugged, the blood continued to flow rather freely from the lachrymal ducts.

DR. J. H. PARKINSON had seen the case, and for a time it was certainly quite alarming. Owing to the shallowness of the pharynx, it was exceedingly difficult to adjust the posterior plug. When everything had been secured and the bleeding had, apparently, been controlled, blood began to flow from the lachrymal ducts in quite a free stream. This gradually decreased until the bleeding was finally arrested. The occurrence of a hemorrage from this source certainly indicated the amount of blood pressure in the nasal cavity.

DR. H. H. LOOK inquired whether the application of cocaine to these growths increased the liability to hemorrhage. In his experience, bleeding began when the capillaries relaxed.

DR. T. W. HUNTINGTON said he had heard Dr. J. F. Morse say that he never removed the tonsil on account of the great danger of hemorrage following the operation.

DR. F. B. SUTLIFF said that in such cases we were likely to encounter patients who were very prone to serious hemorrhage. He mentioned the case of a lady he had attended two years ago in her confinement. The hemorrhage was serious at the time, and the subsequent flow was altogether too free to feel easy about. Two days ago this patient had come to his office stating that she had had a tooth extracted. She was bleeding profusely, was exceedingly pale, and had evidently lost a good deal of blood. With a large exposed surface, as in the class of cases alluded to by Dr. Briggs, such a patient would be a source of grave apprehension.

DR. THOS. ROSS said a simple and effective way of arresting hemorrhage of this character was irrigation with hot water.

DR. BRIGGS, in replying, said he thought that cocaine contracted the vessels and in this way acted as a styptic. Regarding the fatality of the operation, deaths from this cause were very rare. The late Dr. McKenzie, whose experience had been perhaps greater than that of any other operator, had never met with a fatality. On the other hand, it was certainly true that for one that might die from operative interference, hundreds suffered for the want of it.

DR. T. W. HUNTINGTON briefly reported a case of unusually large foreign body removed from the knee joint [to be published].

DR. W. A. BRIGGS exhibited several new instruments which he stated he would describe in more detail at some future time. They included a new surgical needle, with a Hagedorn point and a round shank. A vaginal speculum, opening and closing by a ratchet movement, and which was constructed to secure wide expansion at the vaginal outlet. The speaker also showed a recent improvement, simplifying his axis traction forceps, that had been exhibited to the Society some time since.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, January 9, 1894.

The President, W. WATT KERR, M.D., in the chair.

New Member.—FRANK P. WILSON, M.D., was duly elected a member of the Society.

DR. W. F. CHENEY read a paper on "The Pathology and Local Treatment of Puerperal Endometritis" [published at page 57].

DR. W. H. MAYS said the rule of the surgeon was quite plain: remove all detritus, and have cleanliness and drainage. He believed in the use of peroxide of hydrogen in these cases, as he had seen it reduce the temperature 2 or 3 degrees in an hour. There are many cases where the douche fails and the flexible wire curette must be used.

DR. H. GIBBONS, JR., had nothing special to add. It was his custom to use the intrauterine douche whenever unfavorable uterine symptoms appear. He seldom used the curette, but preferred the double current catheter and a solution of the liquor sodæ chlorinatæ. This must be freshly prepared. He could not see any reason for using either douche or curette indiscriminately.

DR. C. E. FARNUM said the use of the curette in fevers resulting from absorption of septic products need not remove the protecting layer of white corpuscles. He had always noticed a rapid fall of temperature following the use of the curette. It removes blood clots, etc., better than any other means and gives a better chance for thorough irrigation. He had used it often and had never regretted it.

A Fatal Case of Pelvic Abscess.—DR. G. W. DAVIS reported a case of pelvic abscess that had resulted fatally. The patient, a well nourished woman, aged 23 years, married 2½ years, had never been pregnant. Three days previous to his visit, and two weeks after her last catamenia, she had complained of lassitude and headache, both of which symptoms were, for her, unusual. Except for a slight chilliness, she felt better the following day. That evening she felt worse, some tenderness over the entire abdomen being noticeable; however, she felt well enough to take a music lesson, make social calls, and to do some shopping. The temperature was 101°, pulse 90, abdomen tender, especially over the epigastrium. There was no peritoneal or intestinal distension; tongue coated, some nausea. The bowels had moved as usual during the day. As there was no complaint of pelvic trouble, the speaker supposed the tenderness was due to her having taken cold, as the muscles in other parts of the body participated. The following morning patient reported that she had vomited frequently during the night, retaining but little of the remedies prescribed. Temperature, 100°, pulse 96; tenderness most severe over pelvic region. There was a firm tumor the size of a walnut in the hypogastric region. *Per vaginam* the cervix, utero- and utero-vaginal connective tissue was very hard and tender, too tender to permit of a thorough examination of the pelvic contents. A diagnosis of acute metritis was made and appropriate treatment ordered. That day the temperature increased toward evening, falling again the following morning, after a restless night, and rising that evening. Vaginal tenderness still too great to permit of examination. The following morning patient reported having had a better night, and that evening the temperatures was 101°, pulse 98, and no tympanites. Patient expected to be all right in a few days. On the fourth day he was hurriedly summoned at 6:30 A. M., and found patient in a state of collapse, abdomen greatly distended, pulse almost imperceptible. The temperature was 105.8°, and a diagnosis of ruptured abscess or extrauterine pregnancy seemed possible. At this time an operation seemed inexpedient, and every effort was made to stimulate the patient, whose condition at 11 A. M. had much improved. At 2 P. M. patient was much worse; the temperature had risen to 106°. Having decided that operative interference was imperative, the abdomen was opened in the median line, a large amount of pus escaping, as well as some gas. The peritoneum and bowels were lusterless, injected, and inflamed, old and extensive adhesions uniting the pelvic viscera. There was an abscess cavity in the left iliac fossa, the left ovary being almost entirely destroyed. The uterus was firmly fixed and unyielding; the right ovary was much enlarged. The remains of the left ovary were removed, but in the condition of the patient it was deemed inadvisable to interfere with the abscess sac; the cavity was irrigated and dried, and a drainage tube inserted. Patient rallied well, the temperature dropping from 105° to 103° in less than an hour. This favorable condition did not last long; patient soon began to fail and becoming comatose, died at 11 P. M., the temperature shortly before death rising to 108°. The speaker said he had reported this case to illustrate the necessity of always carefully examining a case, no matter how trivial it may seem. It was also an illustration of the entire absence of history in some cases of extensive and destructive pelvic inflammations. He did not regard laparotomy as the first procedure in these cases, as many of them could be successfully treated and drained *per vaginam*.

DR. CHARLOTTE B. BROWN said Dr. Davis' case was a very interesting one for future reference. There are many cases of pelvic trouble that deserve a great deal more attention than they get. Very many give rise to few if any symptoms. Dr. Davis' case was undoubtedly one of old ovarian abscess.

DR. C. G. KENYON thought that a larger opening should have been left, packed, perhaps, with iodoform gauze.

DR. DAVIS, in replying, said he had used a drainage tube, so that the abdominal cavity could not be said to have been closed.

Loreta's Operation for Aneurism of the Descending Aorta.—DR. T. C. RETHERS reported the following case: Patient, a barkeeper, aged 40 years, had had gonorrhea, but otherwise no venereal disease. Three years ago he complained of shooting pains over the left shoulder, in the left axilla, and radiating downwards toward the abdomen. He was treated for rheumatism without effect, and has since then lost 40 pounds in weight. Three weeks before entering the German Hospital patient's wife noticed a lump over his left shoulder where he had observed a throbbing sensation. On examination, beyond an emaciated and anemic condition of the body nothing abnormal was discovered. On the left aspect of the thorax, posteriorly, there was a swelling as large as a small child's head, pulsation being visible over all of it. The tumor extended from the third to the seventh rib, overlapping the spinous processes and extending out under the scapula. The skin over tumor was unchanged. The diagnosis of aneurism of the descending aorta was made. On October 18, 1893, the following operation was performed by Dr. J. F. Morse: The tumor was exposed by an incision three inches in length over the most prominent part of the tumor and parallel to the vetebral column. Four and one-half feet of silver wire were then passed into the sac through a canula. There was no hemorrhage; Monsel's salt was used; the skin wound closed with silk sutures and a dry antiseptic dressing applied. On the second day following the operation there was an evening temperature of 102°, with a morning remission; this was also present on the following day. On the 21st the dressing was removed, and commencing abscess of the stitch holes was noticed. Patient complained of feeling weak and of pain over the tumor. November 5th, at 4 A. M., the night nurse's bell was rung violently, and on entering the room patient was found, in bed, dead.

Autopsy.—The left pleural cavity was full of blood, about two quarts escaping. The heart was slightly hypertrophied, valves intact, papillary muscles showing signs of commencing fatty metamorphosis. Bulbous aorta, slightly enlarged, walls thickened, intima showing signs of chronic endarteritis deformans, fatty streaks and patches, slight ulcerations and calcifications. Behind the arch, and descending aorta and extending to the left and right of it, was a large aneurismal sac, divided by constrictions into three smaller sacs, the whole being somewhat pear-shaped. The surfaces of the vertebræ, and of the ribs with which it had come in contact, were atrophied. This was most noticeable on the ribs of the left side, part of the fourth having entirely disappeared. The walls of the sac were very thin, and at the left upper corner was a ragged opening, the point of rupture. Through the opening between the third and fifth ribs the sac had become subcutaneous, and had here enlarged until it extended from the first rib above to the seventh rib below. All the sacs were filled with a hard, partly organized clot; the wire was partly discernible, coiled up in the sacs and covered by the clot.

At the conclusion of the paper **Dr. Morse** demonstrated the abdominal aneurism of a patient upon whom he had performed this operation several years ago, the patient having been cured for a period of four years. A secondary sac had then formed and burst into the transverse colon. The wire and clot, which completely filled the original sac, could be plainly seen. The specimen is particularly interesting, as showing the final result of the case. In another case of aneurism of the abdominal aorta the success, as far as obliteration of the sacs was concerned, was not so complete, but the patient's condition was much improved, and he is still alive and working, three years after the introduction of the wire.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, December 16, 1893.

The President, Luke Robinson, M.D., in the Chair.

Dr. R. W. Baum read a paper and exhibited the patient, on "Notes on a Case of Suspected Multiple Sarcoma of the Skin" [published at p. 68.]

Dr. D. W. Montgomery said: I first saw this case, with Dr. Baum, about three weeks ago. The spots were then quite small, but even at that time, although red in color, they did not give one the impression of being inflammatory foci. They certainly were not flea bites, for they lacked the central hemorrhagic spot. On looking over his cutaneous surface, we ran across a pea-sized, reddish lump, on the inner side of the right thigh, which the patient said had been there for years. Dr. Baum cut this out and gave it to me for microscopical examination. I found it to be made up of embryonic spindle cells, and, as many moles have this structure and yet remain dormant the whole life through, I was disinclined to base upon it such a grave diagnosis as sarcoma. A few days ago Dr. Baum told me that this tumor on the inner side of the thigh had recurred, and was larger than ever, and that he had again cut it out, together with one of those on the body, for a second examination. Both of them were found to be made up of embryonic, spindle-celled tissue with a considerable number of capillary blood vessels, the walls of which were simply rows of spindle cells. There does not seem to be any reason for doubting that Dr. Baum has here to do with a case of sarcoma and, as in most cases of sarcoma of the skin, the primary tumor is located in some of the internal organs. The beginning of last October, Dr. Cohn sent me a most interesting case of sarcoma of the skin, which also may have been primary in some of the internal organs. The patient, a man of thirty-six years of age, enjoyed good health up to ten months before I saw him. He then began to have waterbrash, and five months later commenced to vomit shortly after eating. Three months after this he began to cough, and the vomiting ceased. The cough came on only when he moved around, and was a peculiar, spasmodic, expulsive effort, with very little expectoration. He rapidly lost flesh. Three months before I saw him, a small lump appeared in the skin of the inner, upper aspect of the thigh and spread till it was a large, brawny, lardaceous mass, of a dusky-red color, occupying the upper part of the front of the thigh and the lower part of the neighboring abdominal surface, being deeply wrinkled in the line of Poupart's ligament. The upper border of this mass was not well marked, but its lower border was, giving the impression of a distinct, thick edge; and scattered all along this lower border, in the apparently healthy skin, were a great number of little, freely-movable lumps, satellites to the main tumor. The large mass was evidently infiltrated into the skin, of which it formed a part. Besides this there were a number of other tumors scattered over the body and one in the scalp, some of them being freely movable under the skin, and others infiltrated into the integument itself. The right posterior cervical lymphatic glands were small and hard, forming a bead-like string; neither the left posterior cervical ganglia nor the epitrochlears were demonstrable. He never had had any venereal disease. The kidneys were probably implicated in the disease, for frequent micturition of a scanty, turbid urine, loaded with urates and containing albumin, had developed. There were some pus corpuscles in it, but I do not think enough to account for the quantity of albumin. Neither the liver nor the spleen were demonstrably enlarged. A good-sized piece was cut out of one of the tumors on the back, and found to be sarcomatous; that is, embryonic spindle-celled tissue. The blood was normal, and there were no tubercle bacilli in the sputum. Dr. Cohn and I put him on Fowler's solution, in gradually increasing doses, as affording him some little hope of checking the disease. He was, however, only able to take eighteen drops a day on account of irritation of the stomach, and it was not thought advisable to give the drug hypodermically, as he went right along developing new tumors and running down in health. After being under observation about two weeks, his breathing became much embarrassed, and the left side of the chest began to bulge out. Dulness and absence of breath sounds took the place of pulmonary resonance and vesicular murmur over the left lung, except at the apex. The breathing was puerile over the right lung. The heart sounds were normal, but masked. He evidently had an effusion into the left pleural cavity, but before we had an opportunity to draw it off he left our care to receive comfort in some other direction. In reply to an inquiry, the speaker said there was no pigmentation in either case. Frequently in primary sarcoma of the skin there is no pigmentation. One case, of Dr. McNutt's, occurred under the ball of the foot, an unusual place; it generally appears on the tread of heel.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, December 4, 1893.

The President, ALBERT ABRAMS, M.D., in the Chair.

DR. S. M. MOUSER read a paper entitled "Microörganisms and their Relation to Disease." [Published at p. 69.]

DR. H. E. SANDERSON read a paper entitled "Serum or Phagocyte—Which?" [Published at p. 76.]

DR. F. Z. BAZAN said there was still much uncertainty as to the cause of immunity, though the fact that vaccination produces in certain cases a condition of immunity is no longer disputed. This was first known when Pasteur attenuated the germ of chicken cholera by heat, and produced in fowls a mild disease which rendered them immune to otherwise fatal inoculations. The theories of immunity from the occurrence in the blood of definite substances are not altogether tenable, because it is hard to understand how such substances can remain for so long in the animal economy. The speaker then read a summary of a recent article by the celebrated bacteriologist, Bouchard.

DR. J. O. HIRSCHFELDER said the investigations of the last few years had led to a large number of very interesting results. The weight of authority at present seems to be against the theory of phagocytosis. However, in favor of this theory are the phenomena described by the term chemiotaxis, first observed by Dr. Buchner, of Munich. Dr. Buchner found in bacteria proteid substances having the power of attracting the white blood corpuscles. He found that besides these albuminous substances there were others derived from the vegetable kingdom, and others from the animal, and even some chemical salts which possessed the same powers. It became very clear that the bacteria observed in the interior of leucocytes were, in all probability, dead, and had been surrounded by the ameboid cells. But the question of immunity is not completely solved, if we accept the theory of phagocytosis. It seems strange that the phagocytes should be able to overcome 20 or 30 different forms of bacteria and not others, and should under the influence of substances injected into the system acquire the power of overcoming these. There are not the same difficulties with the serum theory. When a given species of bacteria develops in culture, certain inorganic substances are formed and certain organic, called ptomaines, which are capable of crystalization. They form salts with platinum, which can be precipitated. The platinum salts can then be decomposed, leaving the pure ptomaines. These substances frequently have actions on the animal organism like atropine and other alkaloids. Besides these there are other substances formed, tox-albumins, which if treated with alcohol are precipitated. They may be again dissolved in water and reprecipitated with alcohol, by which process they are isolated in the pure state. When these substances are injected they produce symptoms like the disease. Brueger experimented with the tox-albumins of diphtheria, and produced systemic reactions, followed by paralyses. The injection of a toxine causes an alteration in the serum producing a substance called antitoxine, because of its property of neutralizing the toxine. This, too, may be precipitated with alcohol and isolated. If an animal be inoculated with a toxine, and an antitoxine derived from the action of the same bacterium on a less susceptible animal no symptoms arise; or if the antitoxine be injected after the toxine has begun to show its physiological action, the symptoms pass off. Such substances have been used in the treatment of animals and man, notably in tetanus, whose antitoxine is readily produced in dogs. It has been isolated by Tizzoni, who reports some very favorable results from its use. A very small quantity of the antitoxine is required to produce immunity. The problem of immunity is to be solved on this line. How can these substances remain in the system long enough to give permanent immunity? How can animals remain immune? The answer is, they do not remain immune. In variola, measles, etc., we are continually meeting with second attacks. The case of pneumonia is notorious. The immunity following an attack is of very short duration. The antitoxine of pneumonia has been isolated, and has been used in a number of cases with good results. The duration of immunity varies with different diseases. Albumins do not readily diffuse through animal membranes, so that they may remain a long time in solution in the blood. That they pass out of the body is proved by finding them in the milk, which has been shown to have the power of causing immunity in animals into which it is injected. Ehrlich experimented with certain vegetable substances, and showed the same thing. Abrine, if applied to the conjunctiva, will set up a severe inflammation, and ricine has a similar effect. In the animal body there is produced after inoculation with abrine an anti-abrine, which has the power of rendering an animal so resistant to abrine that a strong solution will not set up a conjunctivitis. Similarly an animal can be made immune to ricine by feeding him for a time on castor beans. This antitoxine is secreted in the milk. The subject is a very attractive one, it is still far from clear, but it promises something for the future.

Dr. S. M. Mouser said Dr. Sanderson spoke of the fact that the proteids derived from different parts of the body are different in their actions on bacteria, and that the glands, such as the spleen, have great bactericidal power. It is interesting to note that when these organs are removed from the body and sterilized, they make the best culture media, and have recently been used as such. Many germs do not grow on agar or gelatine, and some of these we have been able to cultivate on material from these glands.

The meeting then adjourned to examine a series of cultures and microscopical preparations of various species of bacteria prepared by Dr. Mouser.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

Regular Meeting, December 21, 1893.

The President, Geo. H. Powers, M.D., in the Chair.

Embolus of the Retinal Central Artery.—**Dr. A. Barkan** presented an interesting case of embolic artena retinæ centralis. The patient, J. B——, after taking his usual afternoon hot bath (100° F.) of fifteen minutes' duration, noticed at the dinner table, on trying to carve the turkey, that his sight failed him, and he saw only a portion of the bird. On closing the left eye, he found that he was absolutely blind in the right eye; before retiring, however, he found the sight improved, as he could distinguish his own outlines in the mirror, with the affected eye. He could not remember any preliminary symptoms. The speaker saw the patient on the third day after the occurrence, and found the following condition: External appearance and tension of the eye normal, but very slight reaction of the pupil. Optic disc and surrounding parts toward the macula lutea show a delicate, grayish-white opacity. No sign of optic nerve swelling and no hemorrhage. Blood vessels plainly visible. Both the arteries and veins are smaller than usual and there is a marked absence of the smaller branches. The seat of the embolus could not be located, it being most likely in the trunk of the artery. There is a slight circulation noticeable in the vessels of the nasal side of the retina, and a small amount of vision is retained on the temporal side. The left eye is normal and vision, with proper correcting glasses, equals $\frac{6}{6}$. The treatment consisted in massage of the eye, the motion being directed from before backward, and was continued for several days, twice each day; eserine was instilled, to diminish the tension of the globe. After a few treatments with massage, vision on the temporal side was distinctly improved, and the circulation in the fundus was markedly better. This was confirmed by two colleagues, who had seen the patient before the commencement of the treatment. Since that time there has been a gradual, but slight, improvement in the circulation, but no noticeable improvement in vision. The massage has been discontinued.

A case of double-sided glaucoma was also presented by Dr. Barkan, showing the interesting anomaly of arterial pulsation in the retinal arteries of the right eye and venous pulsation in the retinal vessels of the left eye.

SPECIAL CORRESPONDENCE.

GERMANY.

Medical Berlin.—Its Superiority over other Medical Centers.—Cæsarian Section at the Fraüen Klinik.—Prof. von Bergman.—Orthopedic Surgery and Prof. Julius Wolff.—His Operation for Cleft Palate.—Prof. R. Koch.—Bacteriological Examination of the Water Supply of German Cities.

It has been my good fortune, in the past nine years, to visit the capital city of the Fatherland several times, and to spend a few weeks in the various clinics and hospitals. With each succeeding visit I am more and more impressed with the superior opportunities which Berlin offers to the general practitioner of medicine. The superiority over other medical centers consists first in the unrestricted supply of funds for all necessary requirements. Paris and Vienna have made no improvement in the way of new lecture halls or amphitheaters in the past ten years. The same ill-ventilated, poorly-lighted, rough-seated, amphitheaters which, on my first visit in 1884, were years out of date, still do service. London, whose hospitals are still more cramped for funds, is no better as regards student accommodation. In Berlin, however, many modern hospitals and amphitheaters have been erected, and the facilities for good hearing and good observation, particularly in the Sürgical, Gynecological, and Obstetrical Departments, cannot be excelled. The amphitheaters are separate from the hospital, and resemble, in their solidity of construction, their lighting facilities, their decoration, and seating capacity, our modern theaters. As in all other public works of Berlin, the clinics and hospitals are under control of the Emperor and his subordinates. Everything is done with military precision.

One of the most interesting clinics of Berlin is the Fraüen Klinik on Artillerie strasse, the director of which is Prof. Olshausen, successor to the lamented Carl Schräder. During my stay in Berlin, I was fortunate in seeing a Cæsarian section by Prof. Olshausen, at this clinic. The patient was in the ninth month of pregnancy, and so far as I have heard, both child and mother are doing well. It was the eighteenth Cæsarian section since 1880. Eight of the last ten cases have resulted favorably to both mother and child.

The Surgical Clinic presided over by von Bergman occupies another block of modern pressed brick structures. The amphitheater is also of new construction, and first class in every respect. The clinic is as popular with the students as ever, and one must go early and wait long to get a seat, even in the back rows. Von Bergman himself is as erect and soldierly in his appearance as in former years, but the graying of hair and beard show the years to be advancing. He is an idol to the medical student in Berlin.

One of Berlin's most noted surgeons in orthopedic work is Prof. Julius Wolff, an extraordinary professor in the Berlin University. A man of indomitable energy, he carries on his university work, and besides has built up a private clinic and hospital occupying a large four-story building. I had the pleasure and privilege of making the rounds of his visits on several occasions, and also witnessed a delicate cleft palate operation on a six months' babe. During my clinical visits in this private hospital, I was particularly interested in a case of Trendleberg's new operation for the cure of hernia. Prof. Wolff has already performed the operation a number of times, and gives it as his opinion that it is the most successful and simplest for the cure of hernia. It consists in taking a piece of bone from the symphysis pubis and fixing it in the inguinal canal. As a result there is a constriction of the canal, which in all cases up to date has held tightly. Prof. Wolff has operated on one hundred and sixty cases of cleft palate—simple and complicated. As he has probably operated more frequently than any living operator, he has also written more on the subject and stands to-day the best authority on cleft palate in the world. The success of his operations lies in his originality and the facilities at hand. His plan is first to loosen the flaps on either side of the cleft, then after four or six days, when the little patient has recovered from the effects of the first operation (as shown by bodily weight), the secondary operation is done. This consists in trimming the edges of the flaps that juxtaposition may be perfect, and suturing them. The mouth spatula and method of suturing are original with him, and in their perfection I believe the success of his operation lies.

I also visited the Hospital for Infectious Diseases, presided over by Prof. Koch, and met his assistants, Professors Brieger and Petrovsky. This department was erected by the government in 1891, at a cost of $200,000, and is designed solely to further the researches of bacteriology into the causes of disease. It is in this hospital that Koch continues his work with the lymph. You will remember my recommendation of the same, some years ago, in a letter from Berlin, and I am happy to say that I still believe in it—not as a universal cure, but as the best cure for phthisis, in the early stages, that we possess to-day. In the laboratories connected with this hospital, I saw numerous assistants engaged in examining the water supplies of different German cities. This is done systematically and daily at the command of the government. Dr. Weisse, head of the laboratory, told me that the water supply of Stettin still contains cholera germs, it being the only German city at this season, so affected.

BERLIN, December 5, 1893. G. C. SIMMONS, M. D.

GERMANY.

[FROM OUR OWN CORRESPONDENT.]

Influenza.—Boycotting a Hospital.—A Visit to Dr. Unna's Clinic.—An Octogenarian Medical Poet.—Disposal of Refuse.—Homeopathy in Germany.—Treatment of Retroflexion of the Uterus by Vaginofixation.

During the last quarter of the year, influenza has again spread throughout the country from Königsberg to Stuttgart and from Hamburg to Munich, and, although in general of a mild type, it has frequently proved a decidedly dangerous foe, especially to patients who are advanced in years. In the larger towns the cases notified number several hundreds, the unregistered ones probably thousands, and even the open country yields a very large contingent. In Berlin this increase of patients has unfortunately been accompanied by a general boycotting of the Charité, the chief hospital of the city, by the Social Democrats. As a reason for this procedure, which has already lasted several weeks, it is asserted that the building is overcrowded to an unwarrantable extent, that the food is insufficient in quality and quantity, and that the inmates, especially those of the lock wards, are treated more like prisoners and culprits than patients—not to enumerate various minor grievances. Of these assertions the first is undoubtedly correct. The building has long been insufficient as regards accommodation and even sanitary arrangements, and repeated efforts have been made to induce government to take the necessary steps for adding new wards, but hitherto without avail. As to the other complaints, making due allowance for the proclivity of most hospital patients to raise a clamour on the slightest provocation, real or imaginary, there is, notwithstanding, some reason to believe that these, too, are not quite unfounded. Professor Lewin, the *chef* of the lock department, which was principally attacked, did, indeed, when delivering his introductory lecture at the commencement of this term, defend the institution from these charges, but apparently without much success. At present the boycott continues, and a number of empty beds is the result, while elsewhere patients have to be refused admittance for want of room. Altogether, the hospitals of Berlin have of late been subjected to much vituperation. Besides the Charité, which is an institution of the state, we have three principal hospitals belonging to the corporation of the city, Moabit, Friedrichshain and Am Urban. The authorities have been extensively attacked in the newspapers, the plea being that the patients are too numerous in proportion to the medical staff. It has now been decided that no consulting physician or surgeon shall have more than 120 to 150 patients under his care at one time, which, considering the manner in which matters are managed here as regards assistants, etc., is a very reasonable decision.

In large towns the disposal of refuse is a matter of no little importance and difficulty. Of late, attention has been frequently directed to the value of the method of combustion in specially constructed furnaces, which was almost unknown in Germany until the Congress of Demography at London in 1891. In the Berlin Medical Society some interesting notes were read the other evening by Dr. Weyl. Up to the present time some 55 towns have erected furnaces, producing an aggregate of more than one million horse power. In Berlin, very shortly, a number of such institutions will be constructed, capable of consuming some 200 tons of refuse per week. The great advantage of the method is that it is practically inodorous, and that the matter which otherwise easily becomes a source of great danger, by reason of the innumerable pathogenic germs it contains, is rendered inocuous, and is at once utilized for the most various purposes, by transmission of the dynamic forces produced to all kinds of machinery. From a pecuniary point of view, it is also far better than employing garbage for manuring, as the latter process requires months and even years before the product can be made use of, while with the combustion plan we have, perhaps, a smaller profit, but an immediate return.

On the 26th of this month, Dr. Weber, a venerable member of our profession, celebrated the 80th anniversary of his birthday in the enjoyment of fairly good health, barring an attack of influenza, which he has just weathered successfully. Like Oliver Wendell Holmes, he is a poet of good standing, his principal work being an extensive epic poem, called "Dreizehnlinden," or the Thirteen Lime Trees, by which name the ancient cloister of Convey, near Hoxter, is understood. This was the center from whence Christianity was diffused amongst the heathenish Westphalian tribes, and the ultimate victory of the new doctrine forms the leading theme. Although born of humble parentage, by dint of indomitable industry and unusual talents, supported by a sturdy healthfulness and a robust frame, comparable to one of his native Westphalian oaks, Weber has achieved fame as a poet, a respected position as a physician, and esteem in the capacity of a representative for his native circuit in the Prussian Landtag for 32 years. To judge from these two writers, it would appear that the combination of poetry and medicine is exceedingly conducive to longevity. At any rate, we shall not be far wrong when insisting on the necessity of some kind of hobby for medical men, by which they may, for a certain portion of the day, or say the week, completely shift from their minds the worry and strain which the cares of their profession so liberally entail upon them.

Of all the federal states of Germany, Würtemberg is the one most blessed (or otherwise) with a copious supply of homeopaths, though all parts of the Empire contain a fair sprinkling of them. We even rejoice in a number, small to be sure, of periodicals in the Hahnemannian doctrine. But Würtemberg is, it would seem, the El Dorado of these worthies. This is in a great measure due to the fact that the Queen-Dowager Olga has long been a warm adherent of homeopathy, in consequence of having been once successfully treated by a very talented and energetic physician, Dr. Rapp, who happened to have taken to the creed. The latest evidence of the extent of the homeopathic persuasion there is shown by the attempt recently made in the Landtag or House of Representatives to pass a bill enacting that it be made compulsory that in the Royal Medical Council, a number of seats shall be occupied by professed homeopaths. After a good deal of discussion it was decided that the petition be submitted to the notice of the government for further consideration. The victory thus gained by these sectarians, though not in itself of much importance, contrasts very strikingly with the opinion expressed by L. Würchner (the well known author of "Kraft and Stoff," or Force and Matter; etc.), in a review on the occasion of the fiftieth anniversary of Hahnemann's demise. He writes: Homeopathy is a suitable method of treatment for wealthy, unoccupied, nervous, timid, and chiefly imaginary patients, whose disorders will heal under any or without any kind of treatment, and especially if the imagination forcibly steps in to aid the reparative work of nature. In consequence, the method will probably never quite die out, and it must indeed be conceded a certain amount of partly negative, partly positive usefulness, as just explained, in the hands of discriminating physicians. When applied by unskilled persons it can be, however, and undoubtedly exceedingly often has been productive of incalculable mischief.

A little while ago I enjoyed an opportunity of visiting Dr. Unna's dermatological clinic, at Hamburg. This eminent specialist is so well known all over the world, that he may well form the subject of a few notes. By perseverance and natural talent, unaided by any protection from higher quarters, he has attained fully merited celebrity. His clinic consists of four detached houses, one of which serves at the same time for his dwelling, located in an extensive park in one of the suburbs of Hamburg. Accommodation is here provided for a large number of patients, both of the better, as well as of the poorer classes. Although the clinical material thus collected is both varied and numerous, Dr. Unna's chief interest is centered in his laboratory and in the task of unraveling the many mysteries in which a great part of the etiology and morbid anatomy of skin diseases is still shrouded. He is much impressed with the necessity of scientific work in a narrower sense, as distinguished from clinical observation alone, as he maintains that the latter is quite insufficient to procure us that insight into the causation and progress of dermatological diseases which alone affords a firm basis for diagnostic and therapeutic purposes. He considers that the English-speaking dermatologists often neglect this scientific side and lay too much weight on personal observation. Truly but few possess the faculty of working out new methods of research as Unna has done; but it is quite clear that he is right when he says: we must persistently endeavor to discover new methods of examining pathological objects in order to be enabled to see those changes and their agents and products which hitherto may have been unveiled to our eyes.

Dr. Unna's innovations in therapeutics have made him everywhere justly famous, but what he himself considers of greater importance are his new discoveries in the field of the etiology and anatomy of skin diseases. On the latter subject he has just completed an exhaustive treatise, of which he will probably soon edit an English translation. Of his researches in etiology, I will only just mention the latest, that of the bacillus of chancroid, which at first met with some very adverse criticisms, but of the entity of which he is gradually convincing all his opponents.

In one of the latest meetings of the Berlin Gynecological and Obstetrical Society, Professor Dühessen presented a patient on whom he had performed his operation of vaginofixation of the retroflexed uterus two years ago. Since then conception has taken place and run a normal course. The woman nurses her child, feels quite well, and has had no trouble since the operation, which must be described as a complete success. Dühessen claims as a special feature of his operation in contradistinction to others, that he attaches the fundus and not the body of the uterus to the anterior wall of the vagina, thus insuring far greater reliability of the results; naturally the operation is more difficult to perform, as special measures are necessary to reach the top of the uterus. He has operated on 175 cases, achieving a cure in 144, or 82 per cent., while he has lost only one patient (0.55 per cent.) through sepsis. Considering the frequently unsatisfactory results of treatment by pessaries and the inconvenience experienced by those suffering from retroflection, these results may fairly be considered to indicate a valuable advance in the right direction.

December 30, 1893.

CORRESPONDENCE.

The Publication of Physicians' Portraits.

Sir: The reference of the New York *Medical Journal*, in its issue of December, 1893, to our calendar for 1894, demands a reply. While we were not mentioned by name, the reference is so direct that the physicians who received the calendar cannot but know to whom it referred. It has been our custom for several years to send to the medical profession throughout the United States portraits of eminent physicians and surgeons, and, inasmuch as their distribution has been scrupulously confined to medical men of good repute, no objection has been offered by those gentlemen whose likenesses we reproduced. Not a copy of this calendar, nor of any of our other numerous publications, has ever been sent to the laity. Maltine is distinctly not a "patent medicine," nor has it ever been advertised to the public, and therefore we have considered it within our province to distribute portraits just as we have promulgated testimonials from the most eminent physicians and chemists in this country and Europe. We have statistics to prove that 90 per cent. of the physicians of the United States prescribe Maltine. This fact, in addition to the fact that we reach the patient *only through the physician*, would seem to amply vindicate our use of the likeness of a physician whose pictures are on public sale and have continually appeared in the public press, and who is well known as a public man. The portraits referred to were not used to push the sale of our preparations, as was the portrait of Dr. D. Hayes Agnew, recently published by us. It will be remembered that we printed under Dr. Agnew's portrait a facsimile of his indorsement of Maltine. Our only reason for publishing the portrait of Dr. —— was because we thought it would interest his medical brethren, who have shown so high an appreciation of the series of likenesses we have already published. We should like further to say that as soon as objection was made by him we suspended the distribution of the calendars, as we would not knowingly offend even one of the honorable profession to whom we are so greatly indebted. We are, etc.,

THE MALTINE MANUFACTURING COMPANY, New York.

REVIEWS AND NOTICES.

E. B. TREAT announces for early publication a system of legal medicine. A complete work of reference for medical and legal practitioners by Allan McLane Hamilton, M.D., of New York, and Lawrence Godkin, Esq., of the New York Bar, assisted by thirty collaborators of recognized ability. In two royal octavo volumes of about 700 pages each. Fully illustrated. The great need of a standard American work on medical jurisprudence has long been felt, and in this work every department will be thoroughly and reliably treated.

THE ANTIKAMNIA VISITING LIST.—Some time ago we received from the Antikamnia Chemical Company a visiting list, small, neat and compact, almost small enough to be carried in the vest pocket; and having, beyond the firm's advertisement on the inside covers, nothing to increase the bulk. The book contained 23 pages, with space for 20 names on a page, and the firm offered to supply a new book every quarter. For the physician who ordinarily carries a visiting list, this supply would be wholly inadequate, and, as this was the limit to which the company proposed to go, we did not notice the list. The publishers appear to be astonished at the success that they have achieved, and are, no doubt, appalled at the result of their venture. While adhering to their original offer they are unable to go further, and they have accordingly arranged with their printers, J. B. Burr & Co., of Hartford, Conn., to furnish new books at the following rates: one book, 10 cents; 6 books, 50 cents; 12 or more books, 8o cents each. These books, which will contain no advertising, will be sent postpaid on receipt of price.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES FOR 1893. Vols. I to V. Philadelphia: The F. A. Davis Co.

This, the sixth issue of the Annual, was somewhat late in its appearance owing to the removal of the editor, Dr. Sajous, to Paris, and the addition of a number of new workers to the staff. Amongst these may be noticed Dujardin-Beaumetz, Benjamin Ward Richardson and Apostoli, with several others, all well known to students of modern literature. The general plan of the work has been maintained, and illustrations, many of them colored, have been freely used. It is gratifying to learn that this most important work is on an assured basis, and to note that each successive yearly issue bears marks of improvement and continued effort at greater excellence.

OUTLINES OF OBSTETRICS. A Syllabus of Lectures delivered at the Long Island Medical College. By Chas. Jewett, A.M., M.D., Professor of Obstetrics and Pediatrics in the College, and Obstretrician to the Hospital. Edited by Harold F. Jewett, M.D. Philadelphia: W. B. Saunders.

The smaller handbooks are deservedly coming into favor with the hard-worked student and the harder-worked general practitioner. Life is short, not long—oftentimes doubly, even trebly long, by the unnecessary multiplication of words. Among the best of these handbooks is the Outlines of Obstetrics. It covers the entire field of obstetrics, briefly and yet thoroughly, and forms an admirable framework for the larger knowledge derived from experience and medical literature. It may be safely and warmly commended as an aid to the science of the student and the art of the practitioner.

LEONARD'S PHYSICIAN'S POCKET DAY-BOOK. Bound in red morocco, with flap, pocket and pencil loop. Price, post-paid, $1.00. Detroit, Mich.: The Illustrated Medical Journal Co.

This day-book is now in its 16th year of publication. It is good for thirteen months from the first of any month that it may be begun, and accommodates charges for fifty patients daily for that time, besides having a cash department, and complete obstetric records. There is space for the diagnosis of each case, or for brief records of the treatment adopted, following each name-space. The name of each patient needs to be written but three times in a month. It has the usual dose list; poisons and antidotes; urinary tests, exanthematicæ; disinfectants; weights and measures. The book is 7½ inches long and 3½ inches wide, so that it will carry bill-heads or currency bills without folding. It is bound in flexible covers, and weighs but five ounces, so that it is easily carried in the pocket.

CLINICAL GYNECOLOGY; BEING A HANDBOOK OF DISEASES PECULIAR TO WOMEN. By Thomas More Madden, M.D., F.R.C.S., Ed., Obstetric Physician and Gynecologist, Mater Mesericordiæ Hospital, Dublin; formerly Examiner Conjoint Board Royal College of Surgeons and Apothecaries' Hall, Ireland, ete. With 259 Illustrations. Philadelphia: J. B. Lippincott Company.

Dr. Madden's frequent contributions to the medical press of America have familiarized American medical men with his name and teachings, and have led them to desire, if not to expect from his hands a systematic treatise on those subjects in which he has taken so long and so deep an interest. The present volume consists of a series of lectures, forty-seven in number, presumably delivered originally in the medical class-room, and containing a somewhat rapid survey of the diseases peculiar to women. Among these diseases, the first considered is injuries to the perineum. Various methods of repair are dealt with, but preference is given to the method proposed by Duke, which consists essentially of two steps: first, a transverse incision of the recto-vaginal septum, two and one-half inches deep and two inches wide; and, second, the passage of a suture around the entire incision from one extremity to the other, and of the necessary supplementary sutures above and below, which by their adjustment convert the transverse incision, originally at right angles with the axis of the vulvar orifice, into an antero-posterior one, directly in line with this axis. This operation seems to ignore the anatomy of the pelvic floor, but its simplicity, its freedom from danger of sepsis and from loss of tissue, as well as its espousal by Dr. Madden, entitle it to respectful consideration. In speak-of laceration of the cervix, the author says it is of unquestionable importance as a proof of previous delivery "since by no other circumstance can this injury be produced." This statement seems to be too sweeping, for it has fallen to the lot of more than one operator to produce, by instrumental dilatation, a tear important enough to leave permanent proof of its existence. After describing trachelorrhaphy, Dr. Madden adds that no operation more than this "requires that the surgeon's zeal be tempered by discretion." In the treatment of endometritis, he does not accord to electricity the prominence to which many observers believe it entitled, but assigns it, on the contrary, to the limbo of "useless methods." While recognizing the occasional necessity of the surgical treatment of uterine fibroids, he warns against "a too ready acceptance of the doctrine that a woman within the period of menstrual activity, who suffers from uterine fibroma, must therefore be subjected to any operation whatever."

He believes in asepsis, reinforced by antisepsis, and in general demonstrates that to live in the present, it is not necessary to forget the past. In the publication of this work, Dr. Madden has performed a service to gynecology which will certainly be appreciated by his fellow workers.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held January 2, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

Benjamin Apple, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Hisamatsu Arita, San Francisco; Med. Examining Board Tokio, Japan, Nov. 13, '93,
John S. Barrett, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
B. C. Bentley, Stockton; Cooper Med. Coll., Cal., Dec. 7, '93.
R. M. H. Berndt, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Thomas P. Bodkin, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
George W. Burk, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Chauncey Rea Burr, San Francisco; Harvard Univ. Med. School, Mass., June 27, '88.
H. G. Burton, San Diego; Med. Dept. Univ. City of N. Y., Mar. 4, '69.
Rawlins Cadwallader, San Diego; Med. Dept. Univ. Cal., Dec. 14, 93.
James Wesley Clark, Santa Rosa; Cooper Med. Coll., Cal., Dec. 7, '93.
George D. Costigan, San Francisco; Cooper Med. Coll., Cal., Dec. 6, '92.
Thomas E. Cunnane, Santa Ynez; Cooper Med. Coll., Cal., Dec. 7, '93.
Le Grand N. Denslow, Los Angeles; Coll. Phys. and Surg., N. Y., March 1, '76.
Millicent E. Falck, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93
Fred. C. G. Flesher, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Ernest M. Freeman, Lompoc; Med. Dept. Univ. Cal., Dec. 14. '93.
William F. Friedhofer, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Alexander M. Gall, Stockton; Med. Dept. Univ. Cal., Dec. 14, '93.
Cosmas A. Glover, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Franz C. A. Goerss, San Francisco; Alex. Univ. of Erlanger, Bavaria, Germany, Jan. 26, '69.
J. W. Going, San Francisco; Mich. Coll. of Med., Detroit, Mich., March, 3, '84.
George S. Goodhart, Los Angeles; Med. Dept. Penn. Coll., Philadelphia, Penn., March 7, '49.
Max S. Guggenheim, San Francisco; Univ. Basel, Switzerland, May 19, '84.
Carl C. Hansen, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
James L. Hardin, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Herbert Wallace Hatch, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Edward S. Horton, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Clarance H. Hulse, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Luigi Salvatore Jadarola, San Francisco; Coll. Phys. and Surg., Chicago, Ill., March 11, '84.
John Ely Janes, Pasadena; Bellevue Hosp. Med. Coll., N. Y., May 1, '76.
Charles Lee King, Lamanda Park; Chicago Med. Coll., Ill., March 30, '80.
Hugh Lagan, San Francisco; Med. Dept. Univ Cal., Dec. 14, '93.
Charles S. Maguire, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Sherrie H. Manly, Stockton; Coll. Phys. and Surg., Chicago, Ill., April 13, '93.
Francis Martin, Los Angeles; Med. Dept. Univ. Louisville, Ky., March 1, '60.
Charles F. McCarthy, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
J A. McNear, Jr., San Francisco; Med. Dept. Univ. Cal., Dec. 7, '93.
Henry Meyer, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Abd-Ul-Masih Musawwiz, San Francisco; Syrian Protestant Coll., Beyrouth, Syria, July 8, '91.
Ralph T. Orvis, Alvarado; Cooper Med. Coll., Cal., Dec. 7, '93.
Alexander Patterson, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Mark L Pettit, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Henry Lee R. Phelan, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Gardner Perry Pond, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
George W. Rachel, San Francisco; Coll. Phys. and Surg., N. Y, Mar. 3, '74,
Stephen H. Rantz, Lakeport; Med. Dept. Univ. Cal., Dec 14, '93.
Joseph S. Sageser, National City; Jefferson Med. Coll., Pa., April 2, '83.
William K. Sanborn, Oakland; Med. Dept. Univ. Cal., Dec. 14, '93.
H J. C. A. Sartori, San Rafael; Cooper Med. Coll., Cal., Dec. 7, '93.
Sydney H. Schrader, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
Grace Simon, San Francisco; Med. Dept. Univ. Cal., Dec. 14, '93.
W. I. Van Riper, El Monte; Coll. Phys. and Surg., N. Y., Nov. 2, '91.
Moses Wylie Ward, Woodland; Cooper Med. Coll., Cal., Dec. 7, '93.
John Wright, San Jose; Med. Coll. Ohio, March 1, '54.

CHAS. C. WADSWORTH, Secretary,

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from December 20, 1893, to January 20, 1894.

Major David L. Huntington, surgeon, medical director of the department will proceed to Forts Bayard, Bowie, San Carlos, Grant and Huachuca, for the purpose of making the inspections contemplated in A. R. 1662; and upon completion of the duties assigned, will return to his proper station. Par. 1, S. O. 3, Dept. of the Colorado, Jan. 10, 1894.

Captain Louis V. La Garde, assistant surgeon, is, in addition to his duties as attending surgeon and examiner of recruits, announced as temporarily in charge of office of the medical director during the absence of the latter, in obedience to paragraph 1 of this order. Par. 2, S. O. 3, Dept. of the Colorado, Jan. 10, 1894.

Assistant Surgeon, Thomas U. Raymond, having been summoned as a witness before the general court-martial now in session at Vancouver Barracks, Wash., will report to the president of the court without delay. When notified by the court that his presence is no longer required, Assistant Surgeon Raymond will return to his proper station, Fort Canby, Wash. Par. 2, S. O. 6, Dept. of the Columbia, Jan. 12, 1804.

By direction of the Secretary of War, leave of absence for two months, to take effect on or about January 15, 1894, with permission to apply for an extension of one month, is granted Major John D. Hall, Surgeon.

ITEMS.

A Correction.—Dr. R. Harvey Reed has removed to Columbus, Ohio, not to Mansfield, as was erroneously stated in our last issue.

.**Eleventh International Medical Congress**—Dr. Jacobi, of 110 West 34th street, New York, the Chairman of the American National Committee, has received the following information regarding the Congress. "American members will pay on English, French and Italian railways single fares for double journeys, and will obtain a reduction of twenty per cent. on fares for Italian round-trip tickets. The documents required for their idenitfication will be sent to Dr. Jacobi in January, and Americans intending to visit the Congress will have to apply to him for them. Full particulars concerning the journeys will accompany the documents. Messrs. Thomas Cook & Son, London, Paris, Rome, and Naples, should be applied to for accommodation and for tickets for the excursions at Rome, Naples, and to Sicily. Such excursions will be arranged at Rome, under the guidance of Mr. Forbes, member of several scientific societies and correspondent of the *Times*—for Naples, three days, including Vesuvius, Pompey, Capri, Sorrento, Castellamare, Bajae, etc.—for Sicily, ten days from Naples, including Messina, Taormina, Catania, Girgenti, Siracusa, Palermo, and return to Naples. The fares for members of the Congress will be considerably reduced and will comprise hotel accommodations, carriages, guides, boats, etc.—about 70 francs each, for the three days, and 285 francs for the ten days. Full particulars concerning these excursions will be contained in a leaflet to beadded to the instructions and documents for the journey." From former communications the following are quoted: The members' fee is five dollars, that of their wives or adult relations, two dollars each. Cheques or money orders may be sent to Prof L. Pagliani, Rome, Italy. Credentials have been promised in the near future. When they arrive (none were received last year), they may be too late for many who have started or are about to start. Dr. Jacobi, who has not been informed of the cause of delay, proposes to supply in as official a form as he thinks he is justified in doing, credentials which are expected to be of some practical value. The North German Lloyd has promised to recognize them. It is suggested, besides, that a passport may increase the traveler's facilities. Only the North German Lloyd (22 Bowling Green) and the Compagnie Général Transatlantique (3 Bowling Green), have thought fit to grant any reductions to Congressists. The reductions on Italian railways are available from March 1st to April 30th.

Occidental Medical Times.

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ABDOMINAL SURGERY IN NORTH GERMANY.

By Clinton Cushing, M.D., Professor of Gynecology, Cooper Medical College, San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

In introducing the following remarks, upon what I saw of abdominal surgery in Dresden and Berlin, during the short time spent in those cities the past summer, I desire to pay a tribute to the courtesy of the gentlemen with whom I came in contact. I saw nothing but the greatest kindness shown to all who applied for privileges and opportunities to see and to investigate in professional matters. Socially they evinced the most charming hospitality, and among the agreeable memories of the journey are the pictures of pleasant home life of the doctors in their own houses, the predominating features of which were simplicity, naturalness, and sincerity.

The Royal Clinic for women, in Berlin, is presided over by Professor Olshausen. It is a substantial brick and stone structure, with all the modern improvements in the shape of electric lights and the best forms of sewerage and ventilation, baths, tiled floors, and appliances for cleanliness. Special rooms are set apart for out patients and for the preparation of patients who are to be confined. The Berlin Gynecological Society holds its meetings in the building.

A fine amphitheater has also recently been completed where lectures and demonstrations are given by the professor and his assistants. It is scarcely necessary for me to tell you that the most scrupulous attention is paid to every detail so as to insure cleanliness of places, persons, and things. Indeed, I have never seen as much attention paid to the details, both before and during an operation, as in North Germany.

Operations are generally done early in the morning, six or seven o'clock, and usually the operation begins at the exact moment that had previously been designated. The operator and his assistants are dressed in clean linen garments, with long white gowns, and when the operation begins the door is locked and perfect silence reigns, broken only by the orders of the chief to his subordinates. No story telling, laughing, or anything else is permitted that might distract the attention of any one from their duties. From what I could learn, ether is becoming more used in Germany than formerly, except where diseases of the kidneys exists.

Prof. Olshausen is a slender man of medium hight, whom I should judge to be about fifty years of age; his black hair is getting a trifle thin on top, and a little gray at the temples. His eyes are bright and quick, and his expression very agreeable. His manner, that of a man whose time is all occupied. He has written one of the best books that we have on diseases of the ovaries. As an operator, he is very careful and painstaking, and he evidently believes that what is worth doing, is worth doing well.

One of the most noticeable features connected with his abdominal surgery is the almost universal use of catgut for ligatures and sutures. In the vaginal extirpation of the uterus and in the ligation of the pedicle after ovariotomy, only catgut ligatures are used. In closing the abdominal wall three rows of running catgut suture are made. The first one includes the peritoneum, the second the muscular and fibrous tissues, and the last the skin. In very fat women three or four retention stitches of silk are passed through all the structures of the abdominal wall, as a matter of security, The silk sutures are removed in a week, the catgut is not disturbed and is absorbed in about ten days. Prof. Olshausen showed me numerous cases where the union seemed to be all that could be desired.

The dressing for the abdominal wound is dry benzoate of soda and a layer of absorbent cotton, covered by a bandage. Drainage of the peritoneal cavity is not common in Berlin. Great pains is taken to control all hemorrhage and to cleanse the cavity as well as possible, and then to trust largely to the absorptive qualities of the peritoneum and the powers of the individual to resist any evil tendencies. Personally I do not agree with those who decry drainage, and am more and more convinced each year of its great value in many cases, especially where the peritoneal cavity has become infected with pus, and where there is much oozing of blood and serum.

The opening in the abdominal wall is made decidedly larger than with us, or by the English operators. This gives a larger field to work in, but it increases the shock and causes greater exposure of the abdominal cavity to cold, in my opinion increasing the risk, especially where the operation is a prolonged one. The Trendelenberg position I saw used but once or twice, and in spite of its manifest advantages in certain cases, operators have found that ordinarily the prone position is the best. I had come to this conclusion two years ago, after having used the Trendelenberg position in several cases, being convinced that the gravitation of blood and fluids into the upper part of the peritoneal cavity was a serious disadvantage.

In the removal of large uterine fibroids by abdominal section there is a growing disposition to remove the entire uterus, including the cervix, and thus far with very good results. My observation leads me to the conclusion that success by this method rests almost entirely upon the fact of the free drainage below and the prevention of infection of the site of operation from the vagina. With previous thorough cleansing of the vagina and the removal of the cervix, with its many diseased glands, and the subsequent filling of the vagina with antiseptic tampons, the peritoneal cavity is protected. Whether total removal will be followed by subsequent prolapse of the intestines into the vagina can be determined only by trial.

If peritonitis develop after an abdominal section, no antiseptic is given. Sufficient opium is used to control pain, and a saline laxative is given every hour, assisted by large rectal enemas, until purgation ensues. Personally, I have found calomel, in two-grain doses every hour, the most practicable and useful remedy in these cases. Reopening the abdomen and washing and draining after the peritonitis has fully developed, has been followed by good results in a few cases; it is usually of little avail.

Dr. August Martin is one of the most prominent figures in gynecology in Berlin, by reason of the large amount of work that he does, and on account of his many writings. His father was the celebrated professor of obstetrics in the University of Berlin forty years ago, and was present at the accouchement of the Princess Victoria, when the present Emperor was born. Dr. Martin is a very large man, weighing, I should judge, nearly two hundred and fifty pounds, and is endowed with untiring energy and industry. He has a large private hospital and clinic, and I have seen him do five abdominal sections in one morning. He has private classes attendant upon his operations at certain seasons, and has a large following of students from all parts of the world. He is a typical German in appearance, is very busy, and has little time for anything outside of his professional duties. He is evidently working much too hard, and will break down unless he is more considerate for himself.

His methods in operating are different from any other that I have seen. In doing an abdominal section, he sits on a stool at the end of a low, iron table, with the patient's legs sticking out on each side over the end of the table and unsupported. He opens the abdomen rapidly, and, owing to his position, is enabled to use either hand with equal facility, in exploring the abdominal cavity and in operative manipulation. His assistants stand on each side of the patient, and are so expert that the operator seldom is compelled to ask for any instrument or appliance, for the proper thing is placed in his hand immediately it is wanted. His matron, Frau Horn, a short, thick set, jolly, gray-haired, motherly-looking woman, always assists him in his work. She is very intelligent, and is the inventor of a number of instruments and appliances in use at the hospital.

As in Olshausen's clinic, catgut is largely used. In extirpating the uterus, *per vaginam*, no compression forceps are used; the broad ligaments are tied in sections with catgut. In laparotomy, he makes a large incision, and, with large, flat sponges, his assistants hold the intestines out of the way. Frau Horn made a suggestion that, in order to prevent adhesions between the opposing surfaces of peritoneum after operations, a sponge saturated with olive oil, sterilized by boiling, should be introduced into the abdominal cavity, and the peritoneal surfaces given a coating of oil. This has been repeatedly done during the past few years, and apparently with good effects, but the final conclusion as to the value of the method has not yet been arrived at.

Martin's method of dealing with sub-peritoneal fibroids of the uterus is well known. The peritoneum over the tumor is laid open and the mass shelled out, with the fingers and the handle of the scalpel, like a pea out of its pod, the sub-peritoneal tissues with the line of incision in the peritoneum being carefully closed with catgut and a running suture, a satisfactory method of dealing with sessile growths.

Martin is an ardent advocate of vaginal extirpation of the uterus for carcinoma. He has operated over one hundred times, and in the last English edition of his book, published by Dr. E. W. Cushing, of Boston, a most excellent work, he claims that in forty-four cases where it could be shown that the disease did not extend into the tissues outside the uterus, 70 per cent. remained well two years and a half after the operation.

The work of Leopold, of Dresden, is deserving of especial mention. His excellent hospital for women is under the patronage and control of the royal family of Saxony, and was formely supervised by Winkel, now of Munich, who did much to make it famous. He was succeeded by Leopold whose record in cesarean section is remarkable. His last statistics that have come to my notice show forty-one cesarean sections, with the loss of three mothers and the saving of a large proportion of the children. The frequency of such cases in Dresden is due to the large number of dwarfed and deformed people in Saxony, on account of poor food and overwork. Many of the poor women are brought in carts, long distances and in a deplorable state, and it is wonderful that so large a proportion recover.

Upon entering the hospital, the patient is taken into a large room, all clothing is removed, and a number of nurses set to work upon her and scrub her with soap and hot water, inside and out. This is followed by antiseptic washes and douches *ad libitum*. The patient is then taken to the operating room, where antiseptic precautions of every kind are observed. The abdomen and uterus are rapidly opened, the child extracted and given to an assistant, the placenta removed and the incision in the uterus closed by deep interstitial silk sutures, unless there is reason to believe that the uterine cavity has already become septic. In this event, a Porro operation is done, the body of the uterus is removed and the stump treated externally, which was the case in the instance where I saw the operation last July.

I also saw Leopold operate in a case of extrauterine pregnancy of two months' standing. His methods are admirable, decisive, clean, rapid, and, what is most important, he is remarkably successful in what he undertakes. He is very cordial to visitors, and is surrounded by a large class of young graduates in medicine, many of whom reside in the hospital where the material for obstetrical and gynecological work is abundant.

Compared with other parts of the world, the surgery of North Germany gives the impresssion of being very satisfactory, the most pronounced features being scrupulous cleanliness and the administration of few drugs, the power of nature and the absence of septic infection being, in the main, relied upon for the recovery of the patient.

For the younger men in the profession, it is difficult to appreciate the remarkable advances that have been made in surgery during the past twenty-five years, especially since the era of Lister. An era that will stand out in all future histories of medicine as one of the most brilliant and remarkable, to be compared only with the great era of cellular pathology, and with the introduction into our art of instruments of precision, such as the clinical thermometer and the modern microscope.

The magnificent structure of modern surgery, that is being erected at the present day by active workers in all parts of the field, is likely to be enduring, from the fact that it is based, not so much upon individual opinion and skill, as was so markedly the case in former years, but upon the use of these same instruments of precision which leave no doubt as to the exact facts. There is now no chance for an argument between educated men as to whether a given specimen of sputum contains the bacillus of tuberculosis. The question of the exact temperature of the body in a given case of disease is at once determined accurately, and much speculation prevented and time saved.

We are, indeed, living in a golden age of progress and discovery; and the end is not yet, and great things are promised in the near future to those who are investigating the causes of disease. One of the most hopeful signs of the times is the simplification of methods and of ways and means of managing the sick, especially in surgical matters. In other words, mathematical exactness is slowly, but surely, taking the place of theory and guess-work.

To whom do we owe, in large part, these modern improvements in exact methods and good results? Undoubtedly to the plodding, painstaking, patient work of the Germans. It does not seem possible that any one can go to their schools of pathology without being filled with admiration for their labor and fidelity in working out problems to a successful issue, that we may the better understand the nature of disease.

636 Sutter street.

REPORT OF A CASE OF FATAL SECONDARY HEMORRHAGE AFTER REMOVAL OF FAUCIAL AND PHARYNGEAL TONSILS.

By A. Barkan, M.D., Professor of Ophthalmology, Laryngology, and Otology, Cooper Medical College, San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

Opposed as I am to sensational, and often incorrect, reports of medical cases in the daily press, I think it is our duty to bring such cases before a forum of medical men, in order to give and to receive information. In this spirit, therefore, I lay before you this report.

H. L——, 6 years of age, strumous, pale, a constant mouth-breather; great difficulty in breathing during sleep; voice dull and throaty; fair hearing. On examination, I found the boy's faucial tonsils considerably enlarged, more so on the right than on the left side. The rhinoscope showed a bulky cushion-like pharyngeal tonsil, sufficiently accounting for the difficulty experienced in breathing. The boy greatly resembled his mother, a woman about 30 years of age, with faucial tonsils considerably enlarged, and an adenoid cushion in the vault of the pharynx. The father was a man apparently of the same age, and healthy looking.

As I had operated on several cases amongst acquaintances of the boy's parents, no hesitation arose as to the operation. The father was present; the boy was seated on the knee of Dr. Swett, my assistant, and firmly held by him. I removed with the guillotine first the right, and immediately afterwards the left tonsil. In thus doing there was a rather stronger flow of blood than is usual, although not enough to interfere with the immediate removal of a very large pharyngeal tonsil by means of Gottstein's curette, in which I have implicit faith.

The whole operation did not occupy more than a minute; the bleeding subsequently was copious, but soon subsided into the customary discharge of bloody mucus, so that the boy was enabled to be taken home in a cab by his father, after the lapse of something over half an hour. Instructions were given to keep the boy perfectly quiet, and to supply him with iced milk and liquids.

About 2:30 P. M., some hours after the operation, a summons was received from the patient's home, to which we immediately repaired, and found the boy in bed, on which were many clots of blood which he had vomited half an hour previously. The vomiting was preceded by nausea and restlessness. The patient, on general inspection, appeared in good condition; no marked pallor; pulse good; brain clear. We took him carefully out of bed and examined the throat; no bleeding point or surface could be perceived, neither was there hemorrhage from the naso-pharynx It seemed evident then that a good deal of blood must have been swallowed during and immediately after the operation, and had, as is usually the case, been thrown up. We therefore decided that it would be unwise to again disturb the child as, after repeated examination, no trace of bleeding could be found. Dr. Swett remained with the patient over an hour, leaving instructions on his departure that the iced drinks should be continued, and the child be kept perfectly quiet.

On Dr. Swett's return an hour afterwards, at 5 o'clock, he found that the child had slept a little, though he had at times been excited and restless. He then once more examined the throat carefully and could perceive no bleeding. Before leaving he impressed on the parents the necessity of keeping the child entirely free from any excitement; he was then quiet and in apparently a normal condition. In about an hour and a half's time Dr. Swett was again summoned by the parents, who were greatly alarmed by a recurrence of bleeding and the sudden sinking of the child. He found on inquiry that, after a period of excitement and restlessness, the boy had cried and coughed considerably, bringing on an attack of vomiting, in which large clots of bright red blood had been thrown up, clear blood flowing from both nose and mouth at the same time. As the child was evidently in a very critical condition, Dr. Swett summoned me at once. On my arrival I saw at a glance that a moribund child was before me. There was deathly palor of the face, skin cold and clammy, pulse thread-like, dull glazed eyes, breathing hurried and superficial, excessive thirst and restlessness.

As Dr. Herzstein, the family physician, coincided in my opinion as to the precarious condition of the patient, we concluded that it would be expedient to call in surgical aid before changing the boy's position for further treatment. Meanwhile several subcutaneous injections of whisky were administered, and a large enema of warm salt water; bottles of hot water were applied; the child was fed with milk and whisky, which he took eagerly and copiously, and he rallied somewhat under the stimulation. During this time there was no bleeding from the nose or mouth, and certainly the boy swallowed no blood.

Dr. Morse, on his arrival, advised placing the child under ether, with a view to thoroughly cauterizing the cut surfaces, and thus preventing a recurrence of secondary hemorrhage. The child was placed on a table, the ether acted favorably; Dr. Morse pulled the patient's tongue forward and examined the throat as well as possible, no special source of bleeding could be detected. He then applied the Paquelin along the whole surface, and the boy was put back to bed. He came out fairly well from the effects of ether, although becoming rather unruly, throwing his arms and legs about, which necessitated holding him in bed. Noticing, when Dr. Morse was about to leave, that some blood was trickling from the child's nose, it was suggested that he should once more examine the throat; the child resisted, and during the efforts made to open his mouth a sudden gush of blood took place from it, with a peculiar sound as if blood had found its way into the trachea. The child gave a gasp and (at about 11 P. M.) stopped breathing. All attempts at revival proved fruitless.

Reviewing this distressing case, it is of great importance and interest to take into consideration the various points connected with it, in order to ascertain the most probable cause of its fatal termination. As far as the operation is concerned, I have no hesitation in stating that it was perfectly performed. The conclusion must, therefore, be, that the boy was a bleeder, or that secondary hemorrhage, arising from an injured blood vessel, occurred. In reference to this the "American Text-book of Surgery," edited by Keen & White, says: "Bleeding after tonsillotomy is sometimes severe; from time to time fatal cases have been reported, chiefly in patients suffering from hemophilia." So far as this case is concerned, a disposition to hemophilia might have prevented the formation of firm thrombi, thus making the assumption of secondary hemorrhage still more probable.

Amongst the possible causes of dangerous hemorrhages after excision of a faucial tonsil are: (1) A lesion of the internal carotid. (2) A large artery in the anterior pillar. (3) The venous plexus at the lower border of the tonsil. (4) One or several large and patulous tonsilar arteries, the last mentioned being by far the most common.

In case of injury to the carotid, there is, of course, violent and continuous hemorrhage, rapidly fatal unless the vessel be ligated. In continued hemorrhage from any of the other arterial sources mentioned, it would be manifested by a spurting from the vessel, by a constant swallowing of the blood, or by its escape through the mouth or nose. In case of venous hemorrhage, or of a parenchymatous oozing, it will, on examination, be perceived; or, if in the vault of the pharynx, blood will be seen trickling down the posterior wall or escaping from the nose.

In the case under discussion, the entire absence of all bleeding, from the time the case was seen at 2:30 and carefully watched till 5:30 P. M., precludes the possibility of a continuous hemorrhage from any of the above surfaces, and makes it evident that, in a fit of crying or struggling, during Dr. Swett's absence, the soft and recently-formed thrombi were forced from the lumen of some of the tonsilar arteries; secondary hemorrhage then followed unchecked until spontaneously arrested by the near approach of syncope, just before our arrival.

What makes this supposition the more probable is that the mother, although at an age when involution of the glandular tissue of the tonsils is supposed to have taken place in a great degree, had very large tonsils. The child inherited this condition, although his tonsils were relatively smaller than his mother's; yet, they may have contained an anomalous number, in size, of tonsilar blood vessels.

Amongst the possible sources of dangerous hemorrhage, following the removal of pharyngeal tonsils, is an abnormally situated and enlarged ascending pharyngeal artery, and the possibility of a prolonged and severe oozing from the curetted surface. There was no visible oozing, but the possibility of secondary hemorrhage from an abnormally-situated, ascending pharyngeal artery cannot be entirely excluded.

In the *American Journal of Medical Sciences* for November, 1893, Dr. Newcomb reports a fatal case in a child operated on at the Roosevelt out-patient department, after the removal of adenoid tissue from the naso-pharyngeal vault. There have been other authentic cases of fatal hemorrhage reported. One, by Hooper, caused by digital examination of a hemophilic subject. Delavan records a fatal case in a child aged 4, and a third fatal case in his own practice in a boy aged 2½ years. Hemorrhage occurred 8 hours after operation, and death in about 24 hours.

Fatal cases of tonsilotomy have been reported, by Velpeau, from injury to the carotid artery, after excising a portion of a tonsil with a bistoury. In Ricordeau's well-known thesis, two fatal cases in the practice of Broca and two in that of Cheselden are referred to.

At the meeting of the Medical Society of the State of California, in April, 1893, I read a paper on enlargement of the pharyngeal tonsil, and the necessity of its early recognition by general practitioners. The paper was based on 180 cases, operated on partly at my private office, partly at Cooper Medical College Dispensary. Not a single serious accident had arisen and, as a rule, the improvement in the breathing, hearing, and general condition of the patients had been quite satisfactory.

During the six following months, 129 cases were treated, with similar good results. This makes 309 cases, of which records have been kept. During the 18 years of actual practice preceding the time when my records were commenced, the number of cases could not have been much less than 25 a year, both in private and in dispensary practice, or 450 during 18 years. This makes the number of cases, operated on without any serious drawback, 849. With one fatal result!

14 Grant Avenue.

A CASE OF TREPHINING FOR IDIOPATHIC EPILEPSY.

By D. D. Crowley, M.D., Oakland, Cal.

Read before the California Academy of Medicine.

Mrs. M——, æt. 26, five years married; one child, æt. 3 years; has had epileptic attacks since childhood, and recently, at least one attack each month. Different periods in life and different conditions have made no conspicuous change in their frequency, though during the last three years her memory has become impaired and speech noticeably defective; but so gradually and insidiously that these conditions could only be contrasted with similar ones of a year or more ago.

For two or three months prior to October 26, 1893, she was under my care and received medical treatment with little or no benefit. On that date she was admitted to the hospital rooms near my office. October 27, with the assistance of Dr. Boyes, of this city, I trephined the skull near the parietal eminence on the left side. This location was selected for two reasons, that of evading important structures, and, possibly, of giving relief to the speech center as well as to the epilepsy.

The only points of interest that I recognized during the operation were the extreme thickness of the skull and the laceration of the dura mater to the extent of one-half the circumference of the bone button, due either to its adherence to the bone, or to the teeth of the trephine; I am inclined to believe to the latter cause.

While I anticipated the possibility of serious symptoms arising from the tearing of the dura mater, the patient did not experience the least inconvenience for five days. The temperature during this time did not rise above 100.5° F., and was most frequently between 99° and 99.5°. The wound was only redressed twice. Ice bags filled with crushed ice were constantly kept in contact with the head.

November 3, the dressing was removed and the wound irrigated. During this procedure a sharp clicking sound could be heard even while standing twenty feet away from the patient. This was caused by the pulsation of the cerebral vessels and the synchronous rise and fall of the dura mater, which would adhere, by means of a plastic matter, to the superjacent bone and new tissue. This sound was overcome by a slight pressure of the dressing, a pressure that was no greater than had been permitted during the preceding five days.

November 4, patient complained of soreness of the tongue, as well as impairment of its motion, which at this time I thought to be due to a slight salivation.

November 5, articulation more imperfect, could articulate only short words, or only one syllable of a long word. The question occurred to me at this time whether this could be entirely a muscular fault or a loss of memory of words. I had already concluded that both centers were faulty, and when, at my request, she endeavored to write a reply to a commonplace question, though ordinarily a good writer, her efforts were now quite as faulty as her articulation.

November 6, patient could scarcely articulate. Considering now that the center of speech was infringed upon, or its functions interfered with possibly by pressure from pus beneath the repairing scalp or torn dura mater, I freely opened the former structure, beneath which I found pus, and unhealthy granulations. The wound over the dura mater was then irrigated. This membrane seemed to be undergoing repair, and without any evidence of pus beneath it.

During the succeeding few days, she gradually recovered her speech, which became more and more perfect each day, until at the end of six days from the reopening of the scalp, she could talk nearly as well as ever, and three days later she left the hospital rooms in comparatively good health, and better, as regards her speech, than before she entered.

November 25, the wound was entirely repaired. At this date (January 15, 1894), I can report that no epileptic attack has taken place during the months of October, November, or December, and memory and health are conceded, both by patient and husband, to be greatly benefited.

1068 Broadway.

ANOMALOUS POSITION OF THE CECUM AND VERMIFORM APPENDIX, AND OF THE SIGMOID FLEXURE OF THE COLON AND RECTUM.

By C. E. Farnum, M.D., Adjunct to the Chair of Anatomy and Demonstrator of Anatomy, Cooper Medical College, San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

Since operations for the removal of the vermiform appendix have been so frequently performed, anomalies in position and relations of this portion of the alimentary canal have assumed much surgical importance. During last December I observed in the dissecting room of Cooper Medical College two anomalies of this character that are of interest.

The first specimen is one of anomalous position of the cecum and vermiform appendix. The subject, a male, came into the dissecting room December 6, 1893. The students dissecting on the two lower parts were Mr. F. P. Gray and Mr. Kusel. In this subject the cecum, or caput coli, instead of lying in its usual position in the right iliac fossa, upon the psoas muscle, occupied a position above the right iliac crest, upon the quadratus lumborum muscle, its length being about the normal, two and a half inches. Its lower extremity was one and a half inches above the crest of the ilium. The appendix vermiformis arose from the inner posterior portion of the lower extremity of the cecum, about two inches above the crest of the ilium, extending inward and downward to a length of three inches, and having a mesentery for two-thirds of its length. The right iliac fossa was therefore empty, being lined by peritoneum over its entire surface.

It is, perhaps, unnecessary to comment upon the difficulties that would arise in diagnosing an appendicitis in a patient whose vermiform appendix is so anomalously situated as in this specimen, or of finding the appendix through a small incision made parallel to the anterior portion of the crest of the ilium, especially if an attempt be made to remove the appendix without opening the peritoneal cavity. In this subject the band of longitudinal fibers on the anterior surface of the cecum was, as usual, continuous with the longitudinal fibers on the anterior surface of the base of the vermiform appendix.

According to my observation in the dissecting room, extending over twelve years as demonstrator of anatomy, variation in position of the cecum and base of the vermiform appendix is quite rare. Although authors have stated that the cecum may remain undescended and be found just under the liver, yet this specimen now shown is the first one in which I have observed the lower extremity of the cecum or base of the vermiform appendix to be situated as high as above the iliac crest. In a few subjects I have observed the cecum and ascending colon to have a long mesentery suspending them to the right iliac fossa and posterior abdominal wall in such manner as to enable them to become easily displaced inward toward the median line of the abdomen, thus permanently retaining the primitive condition of peritoneal fold supporting the small and large intestine. I have, however, observed only a few, at most three or four, of such anomalies. More frequently I have found the cecum projecting over the brim of the true pelvis, and the base of the vermiform appendix occupying a position at the level of or below the brim of the true pelvis.

The other anomaly is one of malposition of the sigmoid flexure of the colon and rectum, thus altering the relations of the cecum and vermiform appendix. The subject, a male, came into the dissecting room December 6, 1893. The students dissecting on the two lower parts were Mr. J. H. O'Connor and Mr. J. I. Gallagher. In this subject the sigmoid flexure of the colon, instead of passing down on the left side into the pelvis from the iliac fossa, took its course transversely from left to right, across the abdominal cavity, to the cecum in the right iliac fossa. Its mesos was attached along a transverse line in front of the common iliac vessels, and extending from about the middle of the left iliac fossa to a point about an inch below the short mesentery attached to the base of the vermiform appendix in the right iliac fossa. This sigmoid portion of the colon thence being continued down as the rectum, entered the pelvic cavity on the right side. This anomalously placed transverse part of the sigmoid colon had, like the transverse colon above, a very movable middle portion with a long mesentery and a right and a left extremity quite immovable but entirely surrounded by peritoneum attaching each extremity posteriorly to the fossa of the ilium. The flexure at the right extremity of the transverse part of the sigmoid colon was held by its mesentery in close relation or contact with the lower extremity of the vermiform appendix, and, therefore, in close relation to the cecum. Distention of either the cecum or this flexure of the sigmoid portion of the colon would produce contact of cecum and sigmoid colon, also of the base of the vermiform appendix and sigmoid portion of the colon. The blood supply to the upper and middle portions of the rectum was from the usual sources, but the ileo-colic artery sent some small branches to the right extremity of the transverse sigmoid colon.

In a patient having such an anomaly, it is evident that, should both the cecum and the sigmoid portion of the colon become distended by hardened fecal matter, the vermiform appendix would be squeezed between two firm bodies and would probably be the seat of severe pain and inflammation. However, in this cadaver there were no adhesions about the appendix, and no evidences of former inflammation in that region. It is easy to understand the misleading or confusing signs and symptoms that would arise in making a differential diagnosis of trouble located below the level of the umbilicus in a patient having such an anomaly accompanied by distention with fecal matter.

703 Market street.

MEMORANDA.

Fracture of Upper Maxilla.

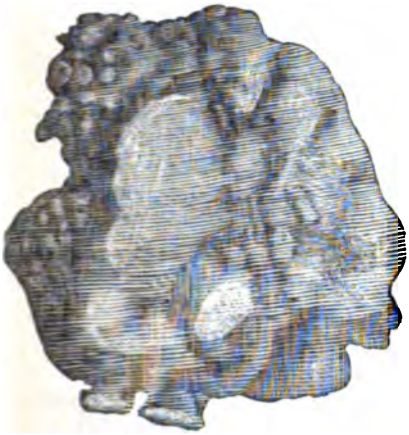
July 6, 1893, G. M——, a laborer, came to the San Mateo Hospital for treatment. He had been "out for a night" in San Francisco, and was attacked by two men. One struck him across the face with a short club, and on examination the upper maxilla was found fractured and very movable. The line of fracture extended across the maxillary bone down the alveolar process on the left side from the symphysis in front to the posterior maxillary border. The bleeding was profuse, and the parts filled with blood and badly swollen; the eye was closed, the nostril occluded, and the hearing *nil.* After depleting the portion of the face involved, the fracture was set by suturing the incisors, two on each side with heavy silver wire, and passing a strip of adhesive plaster (J. & J.) 4 inches wide over the top of the head with each end split, the two front ends passing in front of the ears and under the chin, the two remaining passing back of the ears and the ends overlapping in each instance. The temporal muscles were thus bound down, and the lower jaw brought firmly against the upper as a splint; the head was bound with a Velpeau's bandage, and patient fed through the space left by an absent tooth. Hemorrhage continued for three weeks at intervals, at times profuse, and then ceased; there was little pain at any time. At the end of the second week hearing returned. At the end of the third week nostril opened, and though ten weeks have elapsed since the accident the eye is bloodshot, but improving. The adhesive straps were removed in seven weeks, and patient attempted to use the jaw. The muscles being very unyielding, hot olive oil and massage gave good results, and at present (October 8) there is a fair degree of motion, the union is good, and the callus is not large.

A. E. BALDWIN, M.D.

San Mateo, Cal.

Removal of a Large Floating Cartilage from the Knee Joint.

J. D. P——, a druggist, aged 63, about twenty-five years ago consulted Dr. W. R. Cluness, of this city, regarding a small floating cartilage, lying at the upper external angle of the right patella. Dr. Cluness informed him of its nature and of the probability that in time it would so annoy him that removal would be imperative. For many years thereafter it gave no special trouble, but was never wholly lost sight of. It gradually increased in size, and about one year ago began to affect the joint unpleasantly. He appeared at my office, October 20, 1893, walking, with the aid of crutches, very imperfectly. I found the knee joint considerably enlarged, tense, fluctuating, and painful upon motion. At the point already mentioned was a large, resistant mass, nearly, if not quite, the size of the patella. It was readily movable, and movement with the limb in extension was painless. I advised removal. Accordingly, on November 21st, assisted by Drs. J. H. Parkinson and W. J. Hanna, I operated, under strict antiseptic precautions. The incision through the capsule was an inch and three-quarters in length. The offending body was then removed with forceps, it having no moorings of any importance. A careful examination of the joint revealed numerous polypoid, fibrous masses, of varying size and density, attached to the synovial membrane. These were removed with scissors. The joint cavity was then freely irrigated with a two-and-a-half per cent. solution of carbolic acid. As there was an escape of blood within the capsule, a counter-opening was made on the internal aspect of the knee and a rubber drainage-tube passed through the joint. The operative wound was then carefully closed, an antiseptic dressing applied, and the limb placed on a posterior splint. The drainage-tube was removed on the third, and the wounds were fully closed on the sixth day. The temperature at no time exceeded 100° F., and was normal on the fourth day. The patient returned to his home, in Amador county, twenty-one days after the operation. The accompanying engraving shows the posterior aspect of the mass removed, the facettes, or points of contact with the femur, being plainly seen. Its measurements are two inches by one and three-quarters inches by three-quarters of an inch. So far as I have been able to ascertain, the size of this cartilage exceeds that of any other on record.



Sacramento, Cal. T. W. HUNTINGTON, M.D

A Case of Severe Hemorrhage after Operation for Adenoid Vegetations.

The following case has very forcibly illustrated to me the danger that may follow this comparatively simple operation. The fatalities that have been reported, warn us to adopt every precaution against their occurrence: M. F——, aged 22 years, arrived from the country by one of the afternoon trains, Nov. 4, 1893, reaching my office just before the close of my office hours. On examination, I found extensive adenoid vegetations, but owing to the lateness of the hour postponed operation until the following morning. On the following day, at 10 A. M., I operated with a Gottstein curette, having first applied cocain to the pharynx and pharyngeal vault. A fair quantity of tissue was removed. The hemorrhage was severe for 15 or 20 minutes, but it had ceased with the exception of some slight oozing at the end of half an hour, when she went to her hotel. About 1 o'clock in the afternoon the patient returned to my office with quite profuse bleeding, which she said had begun about two hours previously, but had gradually increased until she had become alarmed; as the bleeding still continued both the posterior and anterior nares were promptly plugged. Half an hour after the plugs were in place the blood was seen to flow quite freely out of the lachrymal puncta, showing considerable blood pressure. I began to fear that the patient was a "bleeder," but she said she had never suffered before from excessive hemorrhage. Perfect quiet was enjoined, and she was sent to Ridge Home for the night, with instructions that I was to be called in case the hemorrhage should return. Fortunately there was no recurrence, and the plugs were carefully removed, with as little disturbance to the clots as possible, about 24 hours after they were introduced. Only slight oozing took place after their removal, but she was advised to remain in the city one day more. After her return home she had no recurrence, and she wrote me she felt much improved since the operation, in spite of the somewhat alarming loss of blood. WM. ELLERY BRIGGS, M.D.

Sacramento, Cal.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and

HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Surgical Treatment of Uterine Prolapsus.—According to DR. PAUL LEGOND there are three varieties of this disease: (*a*) Prolapsus with evident defect of the pelvic floor. (*b*) Prolapsus with healthy pelvic floor, but with some uterine lesion requiring intervention. (*c*) Prolapsus caused by defect of the suspensory ligaments alone. (*a*) Prolapsus with defect of the supporting ligaments: *Operate upon the perineum alone:* (1) If there is neither rectocele nor cystocele; (2) if the uterine mucosa are healthy; (3) if the uterus is not hypertrophied; (4) if the uterus is not the seat of a neoplasm; (5) if the annexes are healthy; (6) if there is no tumor in the pelvis which may crowd the uterus; (7) if the suspensory ligaments are not weakened. *Always associate suture of the perineum:* (1) With appropriate vaginal resections if there is a cystocele or a rectocele; (2) with curettage and resection of the cervix in endometritis and lesions of the cervix; (3) with Huguier's amputation in hypertrophied lengthening of the uterus; (4) with hysteropexy in relaxation of the suspensory ligaments. *Postpone perineorraphy until after vaginal hysterectomy:* (1) When the uterus is fibroid or cancerous; (2) in bilateral inflammation of the annexes; (3) in cases of periuterine tumor when laparotomy is not indicated; (5) in hypertrophied lengthening of the uterus, when relaxation of the suspensory ligaments indicates hysteropexy. (*b*) Prolapsus with healthy supporting ligaments and a uterine lesion requiring either Huguier's amputation or hysterectomy. Here there is no vaginal or perineal operation necessary, and the indications have been already given: Curettage and amputations of the cervix in endometritis;

Huguier's operation in hypertrophied lengthening of the uterus in young women, with hysteropexy if relaxation of the suspensory ligaments requires it. Vaginal hysterectomy is indicated: (1) In neoplasms; (2) in bilateral lesions of the annexes; in periuterine tumors; in irreducible prolapsus; in hypertrophied lengthening of the uterus occurring in patients past the menopause, when relaxation of the suspensory ligaments requires simultaneous hysteropexy. (*c*) Prolapsus caused by defect of the suspensory ligaments alone. Cases of this kind are clinical curiosities, and hysteropexy is the only indication.—*Gazette de Gynécologie*, January 1, 1894.

The Ecbolic Action of Sugar in Labor.—In notes sent to the "Accademia dei Lencei," PROF. N. MOSSO and PROF. LUIGI PAOLETTI speak hopefully of the ecbolic action of sugar in labor, and DR. BOSSI, director of the Geneva Obstetrical Hospital, recommends its administration in cases of uterine inertia without urgent indications of surgical intervention. Dr. Bossi experimented with this remedy in eleven cases of uterine inertia, in ten attaining most favorable results. He administered 30 grammes dissolved in 250 grammes of water, repeating the dose in two hours, if necessary. Favorable action began in about half an hour after the administration of the sugar, and in nearly every case brought about spontaneous expulsion of the fetus. A second dose always stimulated the wearied uterus to further effort. Sugar is not a toxic substance like many of the remedies which excite uterine contraction, nor does it cause uterine cramp, or occasional retention of the placenta, like ergot and the substances derived from it. While Dr. Bossi does not regard his experiments as conclusive, he hopes that they will lead to further study, in the laboratory as well as the clinic; study which may result in the introduction of a safe and much needed ecbolic agent.—*Annali di Ostetricia e Ginecologia*, November, 1893.

Pathogeny and Prophylaxis of Movable Kidney in Women.—In the pathogeny of movable kidney, the following etiological conditions must be considered: Movable kidney is generally confined to women; it is exceptional in children; it does not appear until after adolescence in young girls; it is more common in women who have borne children; it frequently coëxists with dyspepsia, dilatation of the stomach, and gastro-intestinal atony; it is especially frequent in patients whose abdominal walls are lax, and who exhibit other indications of flaccidity of the muscular tissue; crural, hemorrhoidal, or generalized phlebectasia, and relaxation of the bronchial muscles. Movable kidney is often apparent after rapid emaciation, or alternate *embonpoint* and emaciation. These etiological conditions with one exception are common to both sexes, and it is difficult to see why this disease is almost wholly confined to women, without recognizing constriction of the base of the thorax by corsets as an important factor. Dilatation of the stomach produces tumefaction of the liver, and this organ would then push out the short ribs if it were not prevented from doing so by the corset. It is forced instead to crowd the abdominal viscera, especially the right kidney, which is thus lowered, little by little, and transformed by some accident or mechanical cause (a fall, horseback riding, severe vomiting, expulsive efforts during labor, sudden extraction of a large abdominal tumor) into a movable kidney. Gastro-intestinal flatulence, or any condition capable of frequently varying intra-abdominal pressure, is a predisposing cause; but to explain the occurrence of movable kidney, we must add to this innate or inherited weakness of the abdominal walls and extreme thoracic constriction. As a prophylactic measure we should advise patients suffering, among other nervous symptoms, from gastro-intestinal atony, to avoid food likely to produce flatulence, and to give up stiff corsets. Strychnine may be given with benefit. An elastic and *well fitting* abdominal bandage is useful as a preventive measure, and is sometimes the best palliative after the disease is established.—*Union Médicale*, December 28, 1893.

Treatment of Menstrual Gastralgia.—DR. BARATOUX says menstrual gastralgia is an affection which soon becomes chronic without proper treatment. Gastralgic crises, occurring at first, only during menstruation, return, at shorter and shorter intervals, and it is necessary to question patients closely as to the beginning of the trouble, in order to establish its relation with the catamenial period. Menstrual gastralgia, like most uterine reflexes, is generally connected with lesions of the cervical canal, the reflexogenic zone *par excellence* of the utero-ovarian system. Local examination usually reveals endocervicitis, with or without ectropium, with or without stenosis of the uterine orifice. If the physician is called during menstruation, he may advise, as symptomatic medication, the following prescription:

Bromide of Potash	gm. 4
Tincture of Aconite	gm. 1
Muriate of Morphin	gm. 0—02.
Distilled Water	gm. 95—M.

S.—One coffee spoonful every hour until relief is obtained.

After menstruation, local treatment is required to remove the exciting cause. Stenosis requires dilatation, but whether or not dilatation is performed, the reflexogenic zone may be quieted by the following topical application: Muriate of cocain, 1 gramme; distilled water, 20 grammes. Introduce a small quantity of this solution by means of cotton wrapped about a Playfair probe, and leave it *in situ* four or five minutes. This simple treatment relieves gastralgia in a few days, and a definitive cure may be attained by remedies appropriate to the uterine affection, or by scraping the cervical canal with excision of the prolapsed mucosa.—*Journal de Médecine de Paris*, January 14, 1894.

SURGERY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and

G. F. SHIELS, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

Gastrotomy by a Valvular Method.—A series of experiments made upon animals, by L. PÉNIÈRES, of Toulouse (*Arch. Prov. de Chir.*), disclosed the fact that if a fold of the stomach, containing muscularis serosa and subserosa, be sewn into a wound in the abdomen, so that stitches include only these external coats, there will follow after a few days contraction of the wound in the abdominal wall, and a fold of mucosa will be found to be hanging free within the stomach. He based upon these observations a theory for gastrotomy. The following operation was performed on a patient suffering from an impermeable stricture of the esophagus. Two days after the incision had been made, and the stomach sewn in, he made an opening through the wall of the stomach and between the layers of the mucous membrane that formed a fold within. A feeding-tube was introduced, which was left *in situ* for a few days. It was afterward removed and only inserted for feeding, the mucous folds forming a valve that closed the opening after the tube was withdrawn. The patient lived 32 days after the operation, and died from inanition.—*International Medical Magazine*, January, 1894.

The Wounds Produced by the Mannlicher Bullet.—M. CHAUVEL has brought before the Académie de Mèdicine, in Paris, a communication by Dr. Demosthenes, describing the effects of small bullets of the Männlicher rifle used in the Roumanian army. These bullets are 6.5 mm. in diameter, and 31 mm. long. Their penetrating power is said to be three times as great as that of the projectiles used by other European powers. When five dead bodies were placed behind one another at half a meter apart, it was not uncommonly found that three of them were traversed by the same ball, fired at a distance of 600 meters. On soft tissues the apertures of entry and of exit are both smaller than with the older style of projectiles, and the extent of the disorganization perhaps less. The bones, on the other hand, were never perforated regularly. In all cases, and at every distance, the factures both of long, flat, and spongy bones were splintered and shattered with great comminution. With the older bullets the arteries were more or less torn, and from that fact there very often arose an arrest of the bleeding due to the action of the bullet itself; by the new projectiles, however, the arteries were cut cleanly. Wounds of the lungs, even when not affecting any larger vessels, yet set up formidable hemorrhages, which certainly were not produced by the old bullets. In experimenting on the horse, wounds of the intestines, when the animal had recently eaten, have shown a true bursting of the viscera, but the injuries were a little less marked when the intestines were empty. It should be added that it frequently happened that the ball separated in the midst of the tissues into very small fragments, which spread on all sides, and so increased the area of destruction. When these bullets were made to traverse a box of sulphur, this was not set on fire. Meèting a small obstruction did not then make them hot, and there is no burning. The range of the weapon is from 3,500 to 4,000 meters; the danger zone is, therefore, considerably greater than before, and the difficulty of bringing help to the wounded, and of removing them out of range, will be proportionately increased, all of which makes it necessary to strengthen the ambulance service.—*British Medical Journal*, January 20, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

Abuse of Cocain in Nasal Treatment.—DR. GEORGE WILKINSON gives very timely warning of the dangers of patients having powders containing cocain for the relief of nasal obstructions. In a great number of cases of hypertrophy of the turbinated bodies and in acute inflammations the relief from cocain is very marked. Many unscrupulous people have taken advantage of this fact, and have placed on the market, powders containing cocain. Dr. Wilkinson has seen a colony of cocain habitues who acquired the habit by the use of snuff largely advertised as a cure for catarrh.—*Journal American Medical Association*, November 25, 1893.

Eye Symptoms in Cerebro-Spinal Meningitis.—DR. R. L. RANDOLPH reports upon the clinical study of 40 cases of cerebro-spinal meningitis with reference to eye symptoms. Probably every case of this disease shows some involvement of the eye. Conjunctivitis and photophobia; contracted, dilated, or unequal pupils: strabismus; pus in the anterior chamber, and keratitis are common. Sometimes suppurative choroiditis and panophthalmitis occur. In the epidemics studied by Randolph, the principal lesions were revealed only on ophthalmoscopic examination. In 6 cases there was optic neuritis, in 1 retinitis, in another thrombosis of the central vein of the retina, and in 19 cases there was great engorgement and tortuosity of the retinal veins, which were also very dark in color. In some cases that exhibited no lesions of the fundus of the eye, it was probable that such lesions appeared at a later stage of the disease. Of 3 cases, which, when examined, presented no eye symptoms, two recovered, and in the other, lesions probably developed later. In 8 cases there was strabismus, all divergent. In several other cases the right eye seemed to be most severely affected. No explanation to account for the greater liability to disease of the right eye is offered, although the fact has been noted by other observers. It would seem that all epidemics of cerebro-spinal meningitis have one or more eye symptoms in common, conjunctivitis and pupillary changes being most frequently met with; but in every considerable epidemic there is apt to appear a special type of eye affections. Thus, certain observers have noticed suppurative inflammation of the uveal tract; others have seen keratitis; still others only conjunctivitis; while in this epidemic, lesions of the retina and nerve predominate. The latter lesions have probably the most important significance as bearing upon the prognosis, which become unfavorable in proportion as they appear early, and are strongly pronounced. It is clear that in all epidemics of cerebro-spinal meningitis a systematic examination of the eyes should be made with the ophthalmoscope. The existence of good vision does not mean a sound nerve or retina. Frequently with a high grade of neuritis the visual disturbances are insignificant. It is surprising to what stage disease of the choroid, retina, or optic nerve can advance without causing any subjective symptoms whatever. Of the 36 cases Randolph examined ophthalmoscopically, but three complained of their inability to see distinctly. When death does not ensue, the optic-neuritis is apt to be followed by atrophy and blindness, that is usually permanent, although in one case he had seen it was stated that the subsequent recovery was complete.—*Bulletin of the Johns Hopkins Hospital—American Journal of Medical Sciences*, February, 1894.

The Eye Treatment of Epileptics.—DR. AMBROSE L. RANNEY has formulated conclusions, from his extensive experience in treating ocular defects, for the relief of epilepsy as follows: (1) In epilepsy, I regard an examination of the eyes (for errors of refraction) and of the eye muscles (for heterophoria) as the first and, perhaps, the most important step toward a search for sources of reflex nervous disturbance. (2) No final conclusion should be reached regarding the presence or absence of heterophoria until sufficient time, patience and skill has been bestowed upon the investigation by one who is thoroughly familiar with, and practises the latter methods for determination of "latent" heterophoria. (3) All preparations of bromides and other drugs that tend to control the seizures should be withheld, as a rule, from an epileptic patient until all possible sources of reflex irritation have been scientifically sought for and, as far as possible, relieved. There may be justifiable reasons, to my mind, for *exceptional* departures from this rule; but I wish to emphatically raise my voice here in protest against the prevalent system of drugging epileptic patients, from the date of the appearance of the first fit, without any attempt being made to ascertain what the causes of the epilepsy may be. (4) I strongly advocate the employment of atropine in every case before final decision is reached regarding the refraction of the eye. It is wise to insure full correction of any existing astigmatism and as near a full correction of any latent hypermetropia as the patient can be made to tolerate, even if atropine has to be instilled at intervals into the eyes of the patient, for several weeks, to prevent a return of ciliary spasm. I have observed many cases of chronic epilepsy that have been relieved of all convulsive seizures, so long as the full effect of atropine upon the ciliary muscles was maintained. (5) No promise that absolute cure can be effected by eye treatment should ever be made to an epileptic; but it is usually safe for the physician and patient to hope that a radical correction of marked heterophoria and abnormal refraction will eventually be followed by decided and permanent benefit. (6) The results in all cases thus far treated by me seem to warrant the conclusion that at least ninety per cent. of chronic epileptics have been better without bromides, after a satisfactory correction of their eye defects, than they ever were when subjected to the influence of drugs. Some have apparently been cured. (7) In cases where negative results have been observed in spite of a satisfactory investigation and correction of marked heterophoria and abnormalities of refraction, I would deem it wise, before resorting to drugs for epileptic seizures, to search for other sources of reflex peripheral irritation, as bad teeth, phimosis, rectal or uterine disease, scars, etc. The detection of chronic kidney disease, syphilis, organic brain lesions, and depression of the skull, is most important prior to the beginning of eye treatment. (8) The treatment of heterophoria by prismatic glasses alone is not curative; nor, in my opinion, are very marked beneficial results to be expected from them. Prismatic glasses are valuable aids, however, in determining the existence and amount of "latent" heterophoria. (9) The duration of the eye treatment of epilepsy varies with the eye problems encountered. The establishment of orthophoria is not commonly effected in epileptics inside of one year; and long intervals of rest between the surgical steps may be demanded, and thus extend this limit of time to two or three years. (10) Too much stress cannot be laid upon the importance of accurately centering all spherical and cylindrical glasses to the pupil when prescribed. An improperly fitting frame may prove a source of great injury to a patient. (11) The objections that are raised before patients by many physicians and some oculists, to the performance of graduated tenotomy upon an eye muscle, "because of its risk, danger of over-correction," etc., too frequently cause unnecessary alarm, and often prevent patients from obtaining the relief that is within their grasp, and which prismatic glasses will not afford. *New York Medical Journal*, January 20, 1894.

Further Observations on Removal of the Stapes.—DR. FREDERICK J. JACK reports 48 cases of this operation, from the results of which he has found much to encourage the adoption of the procedure. From his experience the author draws the following conclusions: (1) The operation is followed by the best results in the class of cases where, from increase of tissue, the effects of suppuration or hypertrophic inflammation, the stapes offers an obstruction to sound waves; by its removal the hearing is improved. The results in cases of otitis media chronica insidiosa, on account of the failure to extract the foot-plate, are not encouraging. (2) Inflammatory reaction is usual and is followed by no bad results. (3) The hearing is not necessarily impaired by the growth of a thin cicatricial membrane over the fenestral niche. (4) Some cases of tinnitus and aural vertigo are relieved, and there is little chance of causing permanent vertigo in cases where it had not previously existed. (5) It rarely happens that a patient is improved for all tones. Improvement in hearing the human voice is out of proportion to the improvement for other sounds, and the reverse sometimes occurs. (6) Failure in some cases may be due to hemorrhage into the labyrinth at the time of the operation. It is believed to be a rare complication, but was thought to have occurred in one or two cases. (7) In removing carious ossicles the stapes, if found diseased, should also be removed.—*Boston Medical and Surgical Journal*, December 4, 1893.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. Simmons, Jr., M. D., Sacramento, Cal.

Symmetrical Herpes Attacking the Ears.—Dr. Lewis G. Glover reports the following which is of interest as the herpes occurred on both ears at the same time, and was associated with an attack of influenza: A boy, aged 14 years, attended at the Victoria Hospital on December 7th. He stated that he had had influenza but a few days previously, and on admission complained of eruption on the ears. Both ears were the seat of a herpetiform eruption, the right being the worse of the two; of the latter, the helix, antihelix, and antitragus were affected, with the intervening fossæ; on the left ear only the upper part of the helix and its fossa were involved. The eruption consisted of discrete vesicles containing a sero-purulent fluid and seated on an inflamed base. The boy gave a history of having had a similar affection on the right ear every autumn for the last four or five years, and stated that last year the left ear was attacked at the same time, but not so badly as the right ear. There were no physical signs in the heart or lungs, and ten days later he was quite well, a mixture of quinine and iron having been administered during that time.—*Lancet*, December 30, 1893.

Odd Methods of Syphilitic Infection.—Under this title Dr. William Judkins reports (*Journal of Cutaneous and Genito-Urinary Diseases*) the following cases of specific infection in an unusual manner: The first week in December, 1892, Mr. B—— called at my office with what he stated was a broken pimple in his scalp. Examination revealed an abrasion with edges that might be termed sloping, though quite superficial; some thickening, with some redness of the adjacent tissue present. The patch, which could be covered with a three cent silver piece, was situated on a line with the occipital protuberance half way between that point and the ear, left side; a slight discharge was present. The gentleman was a "high liver," widower, American by birth, journalist by occupation. Inquiry brought out the fact that the day following the November election (he having celebrated that event quite extensively) he spent the major part of the time in a Turkish bath. Later in the day he visited, as he supposed, a first-class barber, where he had his hair cut with what is known as "clippers," a substitute for scissors, which has for its chief recommendation a saving in time. He stated that he remembered the barber "jabbing" him at about the point of soreness, but, from his condition, gave it no special attention. From the general appearance of the sore at this visit, and as I was loth to believe it was syphilitic—but subsequent events have proven such to be the case—a guarded prognosis was given. Another case that came under my care, late in the attack, some nine years ago, was inoculated through the hands of a barber with a papular eruption of the palms. The lesion in this case was located in the eyebrow. The case was under treatment some three years, and as twice that length of time has elapsed since his discharge, and no symptoms calling for treatment have been seen, or any indications of constitutional trouble in two children born in the last five years, I feel safe in pronouncing him cured. I report the first case not so much from its novelty as to the mode of the introduction of the poison, but to add another case to the few on record going to prove the scalp as not proof against infection, as Ricord at one time held, but who acknowledged his error before his death, as well that we as sanitarians should warn our patients against the use of this villainous instrument that is daily brought into use. To me the case was one of great interest, as for some time it has been my belief that harm could be done by the use of this "clipper." Some five years ago, I was a witness to the fact of the same being used on a head and neck liberally dotted with the characteristic danger signals. No aseptic precautions were taken after use to prevent inoculating the next one coming under that barber's charge. Whether harm was done or not, I cannot say. Certain it is, that in the case reported, such a result was had. A syphilitic, with the eruption of the scalp, had had the clippers used, who was follewed by a dissipated but non syphilitic subject that through the carelessness of the barber became an easy victim.

Metastasis or Shifting Elimination as a Factor in Certain Skin Inflammations.—WALSH (*British Med. Journ.*) advances the theory that certain forms of dermatitis connected with abnormal conditions of the blood may be directly due to the elimination of irritating substances. Uric acid and the scarlatinal virus may be regarded as types of unusual substances circulating in the blood which are capable of causing inflammation of one or more of the channels of elimination. Uric acid in excess, being highly damaging to the epithelium of excretory organs, is able to produce, besides dyspepsia, nephritis, bronchitis, some forms of dermatitis. Metastasis is often a marked feature in gout, a typical eczema sometimes occurring during an acute gouty attack, and disappearing under treatment with colchicum. The skin trouble may alternate with bronchitis or asthma, or with diarrhea. The scarlatinal poison, like uric acid, acts as an irritant upon the epithelium of excretory organs, and may cause dermatitis in addition to nephritis and inflammations of the respiratory and alimentary tracts. He holds that if uric acid be excreted by the bowel, diarrhea results; by the skin, dermatitis; by the kidney, nephritis; by the lung, bronchitis—these various inflammations being the result of excretory inflammation.—*American Journal of Medical Sciences*, January, 1894.

The Etiology of Cystitis.—R. WREDEN, in a preliminary communication (*Centralblatt. f. Chir.*) which refers to bacterial examinations, based upon the researches of Doyen, Clado, Rovsing and others, announces that he had to deal with direct infection from the rectum, rather than with bacterial embolism, as believed by the last named as a result of his own experiments. Wreden's experiments were conducted on rabbits, injury to the mucous membrane of the rectum being produced by means of hot water injections in some instances, the local use of croton oil in others, but more frequently by mechanical injury brought about by the use of a platinum wire. The results of these experiments were as follows: Injuries of the mucous membrane of the anus, even though repeated several times, do not affect the bladder. Injuries of the rectal epithelium of and above the level of the prostate are followed by cystitis. The character and cause of the cystitis are entirely dependent on the degree of the traumatism inflicted and the nature of the infectious inflammatory agent. In these experiments bacteria were found in the bladder identical with those in the rabbit's intestinal canal, or with those introduced into the rectum. The author proposes to shortly publish an account of some clinical experiences which fully agree with the foregoing.—*Brooklyn Medical Journal*, January, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Cinnamic Acid in Tuberculosis.—A. LANDERER gives the result of two years' experience in the treatment of tuberculosis by means of cinnamic acid. He usually prepares a 5 per cent. emulsion with yolk of egg, almond oil, and common salt, which is rendered alkaline by the addition of a 7.5 per cent. solution of soda lye at the time of administration. The injections are made into the brachio-cephalic or cephalic vein by means of a Pravaz syringe, about 1/10 to 2/3 of a cubic centimeter of the emulsion being used twice weekly through a period of not less than three months. He finds that improvement should begin after three weeks' treatment, but that the remedy is useless in phthisis beyond the primary or secondary stages.—*British Medical Journal.*

A New Treatment for Pulmonary Tuberculosis.—G. M. CARASSO began a series of experiments with inhalations of peppermint oil, as suggested by L. BRADDON, and finally arrived at the following method of treatment: Continuous inhalations of peppermint oil are combined with the internal use of an alcoholic solution of creasote with glycerine and chloroform, to which is added peppermint oil in the proportion of 1 per cent. He has already treated 39 cases of tuberculosis, among them several with cavities, and with abundant bacilli in the sputa, and claims to have obtained excellent results, amounting in some cases to cure. The bacilli disappeared in from 13 to 60 days. Cough expectoration and sweating ceased, the nutrition and weight increased, and the physical signs were such as to warrant the belief that *restitutio ad integrum* had taken place in the lung.—*British Medical Journal*, December 9, 1893.

Specific Treatment of Enteric Fever.—E. FRAENKEL has been experimenting with thymus cultures in the treatment of typhoid fever. Thymus cultures were treated up to 63° R., their complete sterility demonstrated by experiments, and the injections were made into the glutei muscles. On the first day 0.5 c.cm. were injected, and no change was noted in the condition of the patient. On the next day 1 c.cm. was given, and this was followed by distinct rise of temperature with slight shivering. On the third day the temperature fell, and 24 hours later there was a further drop. If the treatment was stopped the temperature rose again, so that 2 c.cm. were administered with similar results as before. The course of the temperature determined the further treatment; if there was no rise, the injections were given at two days' interval, the dose being increased each time by 1 c.cm. The fever lost its continued character, becoming intermittent, and in a short time there was complete apyrexia. Along with the fall in temperature there was profuse sweating and copious diuresis; the diarrhea mostly ceased, and the patients appeared to be convalescent while rose spots and enlargement of the spleen were still present. Complications and relapses could not be avoided, but the treatment was efficient in the relapse. The treatment secures a rapidity and uniformity in the course of the disease not hitherto observed.—*British Medical Journal*, December 9, 1893.

Treatment of Epilepsy.—DR. ALEXANDER, of Liverpool, has observed good results in the treatment of epilepsy by means of the combination of borax with the bromides, especially with the bromide of sodium. In 26 cases in which this combination was administered, the fits were arrested for several months in 9 cases; in 17 they were diminished in frequency, while in one they were uninfluenced and in another they became more frequent. But perhaps the benefits of this treatment are more uniform in regard to the mental condition of the patients. Even in those who were subject to post-epileptic mental disturbance, and in others who remained dull and stupid for several days after a fit, the mental disturbances entirely disappeared, There are, however, certain drawbacks to the administration. The full dose sometimes produces gastric disturbance, flatulence, and loss of appetite; but these are usually avoided by care in administering the drug after food, and by caution in increasing the dose gradually. Skin eruptions may also be produced, especially after continuous administration for some time, but these usually subside even without discontinuing the drug. Loss of hair, sometimes complete, is a more serious complication.—*Lancet*, December 16, 1893.

The Relation of the Abuse of Alcohol to Mental Diseases.—The abuse of alcohol must be considered, not only as a cause of insanity, but as a symptom or effect of insanity. There are abundant statistics to show that the habit of intemperance is often inherited. In all probability it is not a craving for alcohol that characterizes this inheritance, but a neurosis, the characteristic symptom of which is a want of inhibition or power of self-control. It will be convenient to consider the action of alcohol as a cause of insanity under the following headings: (1) Alcoholic abuse acting directly as a cause of insanity. In the cases under this heading, the mental derangement is due, in a primary attack entirely, and in subsequent attacks, principally to the toxic action of alcohol on the nerve cells. It may be mentioned that such toxic action is in some cases due to the presence of propyl, butyl, and amyl alcohol as impurities. In such cases, probably, the nerve cells are hereditarily predisposed to the action of alcohol. In the first attack the derangement is purely functional and the patient may recover completely, but is more than ever predisposed to the toxic action of alcohol. In the second and subsequent attacks, the mental derangement is principally functional; but the more numerous the attacks the more tendency is there to organic changes taking place in the cerebro-spinal nerve tissue, until finally the patient does not recover, but develops symptoms characteristic of chronic alcholism, which will be referred to under the next heading. In this class of cases, the mania is liable to be of a type resembling epileptic fever, during which suicidal acts may be committed either purposeless in character or as a result of delusions or hallucinations. (2) Alcoholic abuse acting indirectly through its action on the tissues and organs of the body. Prolonged, excessive indulgence in alcohol produces tissue changes which consist chiefly in a considerable increase of connective tissue elements of the brain cortex, together with degeneration of nerve cells, more particularly those of the deep layers. The attacks are generally gradual in their onset, but occasionally are sudden. They are characterized by suspicions, hallucinations, and delusions, which at first are usually intermittent and varying, while at other times they are fixed. So long as they are intermittent, the prognosis for recovery is good. The organic diseases are generally cirrhosis of different viscera which produce a condition of melancholia. (3) Alcoholic abuse acting in conjunction with moral or physical causes. Strictly speaking, those two causes stand to one another in the relation of cause to effect; they, however, act and react on one another to so great an extent that the effects of both are combined in the causation of the ultimate result. A common example is where business misfortunes lead to alcoholism, or where alcoholic habits lead to failures in business, in both of which cases we have a mental depression associated with the abuse of alcohol. In cases where mental depression has led to alcoholism, the type of insanity is generally delusional mania, but where the alcoholic habits have lead to mental depression, the symptoms are usually those of melancholia. (4) Alcoholic abuse acting in association with certain physical causes: (*a*) sunstroke, (*b*) injury to the head. While many patients completely recover from their injuries, there more frequently are more or less nervous symptoms. In both of the above lesions, one of the most common results is an increased susceptibility to alcohol, and a change in the manner in which the emotions are affected in the early stages of intoxication.—DR. R. H. NOOTT, in *Lancet.*

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M. D., Professor of Pathology, Cooper Medical College, San Francisco

Hemosialemesis Hysterica.—E. JOSSERAND describes under this designation a variety of hematemesis which he has repeatedly encountered among hysterical women, accompanied by dysmenorrhea. The character of the vomited fluid has the same clinical significance as the rusty sputum of pneumonia, for when it is recognized it is pathognomonic. The fluid has a blood-red color and is very watery; it looks as if it had been diluted. It is glutinous and has a syrupy consistency. Another physical peculiarity is that, unlike the blood from hemoptysis, it does not become foamy, and finally, it does not coagulate for a long time. The clinical manifestations attending this condition are as follows: The fluid is removed by one effort. There is suddenly a feeling of impending suffocation, and there appears at once in the mouth the fluid already described. This phenomenon may be repeated daily for weeks or months. Accompanying it we find certain hysterical stigmata. An examination of the fluid shows it to contain $\frac{1}{12}$ of the normal amount of hemoglobin in the blood, and the number of blood corpuscles is diminished one-half. The other constituent is saliva. The fluid consists of 1 part of blood to 10 or 12 parts of saliva: The fluid vomited may originate from the esophagus or root of the tongue, but it usually comes from the stomach, and as it escapes from the mouth is intimately mixed with the saliva which has been caused to flow by the nausea preceding the vomiting. From the foregoing facts, the term hemosialemesis was suggested to the writer. In one of the cases hypnotic suggestion caused a disappearance.—*Wiener med. Presse.*

Sigmoiditis and its Treatment.—M. A. MAYOR considers that constipation is the chief etiological factor in this affection. Constipation acts mechanically and also by furnishing certain effete products which by auto-inoculation conduce to a septic inflammation. The inflammation may be limited to the tunics of the sigmoid flexure (sigmoiditis), or implicate the peritoneal covering (perisigmoiditis). The principal symptom of this affection is the presence of a painful tumor in the left iliac fossa. The cylindrical tumor is movable on palpation. This painful tumor must not be confounded with the sigmoidal cord described by Glenard and occurring in patients afflicted with enteroptosis, further with phlegmon and iliac adenitis, with simple gastro-cholic dilatation and finally with muco-membranous colitis. The treatment consists of rest in bed, liquid or semi-fluid alimentation, daily lavements, and cataplasms to the painful abdominal region.—*Semaine Médicale.*

The Bacteriological Diagnosis of Cholera.—R. KOCH (*Zeitschrift f. Hygiene u. Infectionskrank*), shows that a bacteriological examination for the cholera bacillus by our present methods will take at least two days. An abridgment of these methods is desirous. Koch describes six distinct plans for the demonstration of the bacilli, based on long continued observation. By microscopical examination the diagnosis of cholera can be made in a very few minutes in more than half the cases by an adept accustomed to the differentiation of microbes. All that is necessary in this examination is to place the suspected mucus, discharged in the feces, on an object glass and examine microscopically. To corroborate this diagnosis, there is made simultaneously a peptone and a gelatine or agar, plate culture. A peptone culture is conducted as follows: In a sterilized 1 per cent. strongly alkalinized peptone solution contained in test tubes, the suspected material is inoculated. The test tubes are maintained at a temperature of 37° C. The cholera bacteria require a large quantity of oxygen, and strive to reach the surface of the culture fluid where they develop apart from the other microbes contained in the feces. Usually, after six hours, a pure culture of the cholera bacteria can be demonstrated on the surface of the peptone solution. With the agar plate cultures, the bacteria can be demonstrated in from 8 to 10 hours. With the peptone cultures one can conduct the important cholera-red reaction. This consists in adding to the cholera culture sulphuric acid, which develops a red coloration, characteristic of the cholera bacteria; or, in other words, the cholera bacillus is the only curved organism that yields to this reaction. In doubtful cases the animal experiment may be necessary. For this purpose, we remove with an *oese* the surface of the agar culture, and mix this with 1 c. c. of sterilized bouillon, and inject all into the peritoneal cavity of a guinea pig. Among all the curved bacteria, there are none which in small dosage will create the same symptoms as the cholera bacteria. Immediately after the injection toxic symptoms develop, particularly the rapid fall of temperature, and finally death.—*Münchener med. Wochenschrift.*

A Contribution to the Study of Intestinal Antisepsis.—A. LESAGE and J. DAURIAC refer to the method of Cantani with lavements of medicated fluid in the treatment of cholera. This method is uncertain in its results, mainly for the reason that too little fluid is injected. The following method has been successfully employed on the living subject after experimentation on the cadaver and on animals. By its means, flushing of the intestines nearly up to the stomach can be accomplished. The patient is placed on the bed in a horizontal position with the left hip slightly raised on a cushion, in order to put the cecum in a declivatous position. A soft rubber sound is next introduced into the rectum and slowly passed along until near the middle of the transverse colon. One can determine by palpation the position of the extremity of the sound. The other end of the sound, which is outside the anus, is connected with a rubber tube, 1 meter in length, which in turn is attached to a bottle holding from 8 to 10 liters of fluid heated to a temperature of about 40° C. The reservoir containing the fluid is raised above the patient from 20 to 30 centimeters. The fluid is now allowed to slowly enter the rubber tube under very feeble pressure. To prevent the fluid passing out of the anus, a tampon of cotton or a specially constructed apparatus is placed at the latter situation. The fluid must fill the cecum slowly without distending it. The degree of repletion is indicated by percussion and palpation of the cecal region. The authors emphasize the importance of allowing the fluid to enter the cecum slowly, progressively, and under feeble pressure. About 3 liters of fluid must enter the tube before the small intestines are reached, which is indicated by the colicky pains then experienced. When the reservoir shows that 3 liters of fluid have entered the intestines, and if the level of the fluid continues to fall, the reservoir is maintained at its original hight (20 to 30 centimeters); if, on the contrary, the surface of the fluid is stationary, the reservoir is raised slightly in order to slowly increase the pressure and kept at this point until the reservoir is depleted. The penetration of the fluid into the intestines is not as simple as one may imagine. It is hindered in the entrance by the presence of the intestinal gases, the latter occupying the upper and the fluid the lower part of the intestinal canal. If the method already cited is executed with all regard to details, the entire intestinal canal can be flushed. When 6 liters of fluid have passed into the tube, it penetrates into the stomach as indicated by nausea or vomiting, and the rejection of the fluid through the mouth more or less tinged with the feces. This method is simple and without danger. Its advantages are: (1) The use of large quantities of fluid. (2) The employment of feeble pressure. (3) The horizontal position of the patient, which favors the entrance of the fluid. (4) The declivatous position given to the cecum. Lactic acid, tannin, benzo-napthol, and other antiseptic agents may be used for carrying out intestinal antisepsis. The quantity of liquid to be injected varies with the age of the patient: for the new-born, about 1 liter; for the child, about 2 liters, and for the adult, about 8 liters. The authors have employed intestinal lavage in cholera, enteritis, and icterus. They suggest the employment of intestinal lavage in auto-intestinal intoxications, uremia, intestinal occlusion, etc.—*Gazette des Hôpitaux*, October 17, 1893.

The Prognosis of Pulmonary Tuberculosis.—ARTHAUD bases the prognosis of pulmonary tuberculosis on two important factors, viz: the disturbance of nutrition, and the extensiveness of the lung lesion. The first is determined by weighing. The weight of a normal adult individual, according to the observations of this writer, is the amount, in kilogrammes, of the person's hight in centimeters above 1 meter. Thus, if the hight of a person is 1 meter and 70 centimeters, the normal weight should be 70 kilogrammes. Observations based on many cases show that when a phthisical subject has lost ⅓ of the body weight, there is great danger to life, and if ¼ of the body weight is lost the case is hopeless. The best nutrition for these individuals is the ingestion of 400 grammes of meat and 1 kilogramme of bread in 24 hours. The extensiveness of the lung lesion is not so easily determined. The destruction of lung tissue is indicated not only where bronchial respiration and rales are heard on ausculation, but also in those situations where indeterminate respiration is heard, for the latter indicates fibroid induration of the lung. A more practical means of determining the degree of lung destruction is by counting the pulse. The following figures are only of avail in apyretic conditions and when the patient is not nervous: 90 pulse beats indicate a loss of ⅓ of the lung: 100 pulse beats indicate a loss of ½ of the lung; 110 pulse beats indicate a loss of ¾ of the lung; 120 pulse beats indicate a loss of the entire lung Patients who have lost ¼ of their body weight and ¾ of the lung, are pronounced incurable.—*Wiener med. Presse.*

Pseudo-Leukemia.—A symptom that has been observed for many years in this disease is recurring fever. In the course of this disease, without a chill, there is a gradual rise of temperature to 102.2° F., or higher, remaining at this hight for a day or two to fall by crisis, and after an apyretic period of short duration it again rises; during the fever the enlarged lympathic glands do not change. E. FISCHER assigns as a cause for the fever the presence in the blood and the glands of the staphylococcus pyogenes aureus only during the febrile paroxysm. The microörganisms are not considered by him to be the cause of the disease, but only of the fever. The periodic intermittent character of the fever receives the ingenious explanation that during the febrile paroxysm temporary immunity is secured, and, after this is overcome, infection recurs.—*St. Petersburger med. Wochenschrift*, October 14, 1893.

Tuberculosis.—At the recent German Congress of Tuberculosis, the following resolutions were adopted: (1) *Hospitalization of tuberculous persons.* It is necessary to confine consumptives in special hospitals in groups, according to the stage of the disease. The hospitals must be constructed with movable furniture, so that thorough disinfection can be accomplished. (2) *Inspection of foods.* The foods must be subject to the most careful inspection. At the public abattoirs apparatus should be introduced destined for the sterilization of foods which provoke tuberculosis. (3) *Prophylaxis of bovine tuberculosis.* All animals suspected of transmitting tuberculosis, before being used for food, should be subjected to the experimental action of tuberculin. (4) *Antiseptic cuspidors in the schools.* The dessicated expectoration constitutes the chief cause of tuberculous infection in man. To prevent expectoration on the floor, children should be taught at school to use a cuspidor whenever necessary. This habit inculcated in childhood will persist through life, thus combatting one of the most potent etiological factors of tuberculosis. (5) *Inhumation of consumptives.* The inhumation of tuberculous cadavers constitutes a grave danger to public health. Before burial these cadavers should be subjected to the most rigid disinfection. The next Congress will be held in Paris in July, 1896.—*Revue Médicale.*

A New Diagnostic Sign of Typhoid Fever.—In the last two great epidemics of typhoid fever in Odessa, DR. V. FILIPOVITCH observed a new sign of this disease, which he describes under the name *palmo-plantar sign*, and which consists of a callous appearance and yellowish coloration of the skin in the palms of the hand and the soles of the feet. The parts, as is well known, have a rosy appearance in health, whereas in cyanosis they present a bluish appearance. This phenomenon in typhoid fever he explains by the enfeebled action of the heart, incomplete repletion of the capillaries and dryness of the skin. The phenomenon disappears rapidly during convalescence. Others have confirmed the palmo-plantar sign; and the latter appearing early in the disease constitutes a symptom of great diagnostic value.—*Revue Médicale.*

The Treatment of Diarrhea in Dysentery, Typhoid Fever and Cholera.—In patients suffering from dysentery, AUFRECHT has employed for years morphine with a bland diet, and has nearly always secured good results. He cautions us against the employment of intestinal irrigations in the acute stages of the affection. After this stage, irrigations with a solution of liquor ferri sesquichlor (1:1000), or a solution of nitrate of silver (1:10,000) are of value. In the diarrhea of typhoid fever, he has equally good results from opium and morphine. The same treatment is applicable when the fever is complicated by hemorrhage or perforation. During an epidemic of cholera, if diarrhea occurs in an individual, the latter must remain in bed until the stool resumes its normal appearance. In the diarrhea of cholera, the writer places great dependence on morphine or opium, preferably the former, and maintaining the effects for many days.—*Wiener med. Presse.*

Bright's Disease.—DIEULAFOY directs attention to the fact that albuminuria and edema, two characteristic symptoms of morbus Brightii and uremia, are not always present. In 60 cases of this disease observed by him, albuminuria was absent in one-fourth of the cases. Many of his patients showed no albumin in the urine during their entire sojourn in the hospital. Uremic attacks can be diagnosed from the following symptoms: (1) Disturbances of hearing, which are more frequent than ocular disturbances, and manifested by tinnitus, difficult audition, and deafness. These symptoms were present in 34 of the 60 cases. (2) Menière's vertigo, which resisted all forms of treatment, yielding, however, in a few days to a diet composed exclusively of milk. (3) The symptom known as the *dead finger*. (4) The intractable itching. (5) Frequent desire to urinate, which he describes under the name *pollakiuria*. The latter symptom must not be confounded with polyuria, for in pollakiuria, the amount of urine is not necessarily increased, the frequent urination depending on an irritability of the bladder provoked by abnormal urine. (6) A symptom which Dieulafoy first noticed is the extreme sensitiveness of patients affected with Bright's disease to cold, which he calls *krysesthesia*. (7) The temporal arteries are tortuous and hard, like an atheromatous artery. It is not artheromatous however, the condition depending on a dilatation of the blood vessel, the result of increased blood pressure. In connection with these symptoms, cramps at night in the cural muscles, epistaxis in the morning, and wakening suddenly during sleep as if an electric shock were felt, are signs which, taken in conjunction with the foregoing, although no albuminuria is present, justify the diagnosis of Bright's disease. The writer calls the above symptom group, the *minor symptoms* of Bright's disease, and when occurring in connection with albuminuria and edema, the *major symptoms*. The minor symptoms are characterized by the fact that they rapidly disappear after a milk diet. Albuminuria and Bright's disease are not synonyms. In gouty patients albumin may be observed in the urine for years without any of the minor symptoms already noted. Dieulafoy also noted albuminuria in connection with syphilis and chlorosis without any minor symptoms. In the discussion, G. SEE agreed with the reader of the paper that albuminuria and uremia do not run parallel. He observed, however, that albuminuria is rarely permanently absent in Bright's disease. The presence of albumin can only be negatived when the urine is examined at different times during the day. Albumin may be present during the day and absent at night, and *vice versa*. The minor symptoms noted by Dieulafoy are present in many nervous diseases which have nothing in common with Bright's disease. The following are positive signs of Bright's disease: Edema of the face and the lower extremities, increased arterial tension, diminished toxicity of the urine, and diminished excretion of nitrogenous principles.—*Wiener med. Presse.*

The Etiology of Leukemia.—DR. VEHSEMEYER presents the query: Is leukemia an infectious disease? Although much work has been done during the past few years in determining the infectious nature of this disease, the results thus far are exceedingly indefinite. Various microörganisms have been found in the blood and organs of leukemia patients, but their relationship to the disease has never been conclusively shown. The writer presents the theory that the etiology of the disease is based on autointoxication from the intestinal tract. The fact that in acute leukemia, stomatitis and pharyngitis are frequently present, and that in the chronic form of the disease, intestinal disturbances are common, seem to fortify his theory.—*Münchener med. Wochenschrift.*

Determining the Presence of Blood in the Feces and Vomit.—Dr. H. Weber refers to the great diagnostic importance of determining the presence of small quantities of blood, when a suspicion of ulcer or carcinoma of the stomach or intestines exists. It is not difficult to detect the presence of fresh blood in large quantities, but it is in the determination of a small quantity and altered condition of the blood, that a certain method of examination is called for. He reviews the methods in vogue for such determination. Many of them are faulty, others too complicated for the use of the physician. The following is not only the most simple but also the most practical procedure. It is based on the fact that the blood coloring matter is dissolved in acetic acid and shaken with ether. His method is as follows: A suspected portion of the feces or vomit is rubbed in a mortar with water, to which is added a third volume of acetic acid, and then shaken with ether. If blood is present, the hematin contained in the acid ether will give a tokayer wine color to the solution. A few cubic centimeters of this ethereal extract is poured off; to the latter are added 10 drops of tincture of guaiacum and 20 to 30 drops of turpentine. If blood is present, the mixture will become bluish-violet, whereas if blood is absent, it will be reddish brown with a tinge of green. The reaction just described is more delicate than the spectroscope. In experiments conducted by the writer, the ingestion of 3 cubic centimeters of blood could be determined in the stool. The same reaction may be employed for detection of blood in the sputum or urine. In the examination of the latter in a test-tube, acetic acid and a few cubic centimeters of ether are added and gently shaken. If the ether remains uncolored no blood is present.—*Berliner klin. Wochenschrift.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M. D., Assistant Physician, State Asylum for Insane,
Stockton, Cal.

The Alleged Increase of Insanity.—At the last meeting of the British Medical Association, Dr. Hack Tuke discussed the subject of the alleged increase of insanity. He presented a number of statistics to assist in arriving at a conclusion, covering the period elapsed since 1870. He admitted that the figures, considered by themselves, did present a somewhat alarming picture, but he thought there were circumstances which might partially or altogether account for this increase in numbers. His conclusions were as follows: Since 1870 there has undoubtedly been a large increase in the number of patients in asylums and work-houses, more in the former than in the latter. After deducting the transfers and reädmissions, however, there has not been so great, though still a considerable rise in the number of patients admitted to the asylums during this period. After allowing for the increase in population, there is still an increase in the number of inmates of asylums; this, however, does not prove an increased liability of the community to insanity, if one considers that there is a vast accumulation due to a lower death rate since 1870; and considering the chronicity of the disease and its lamentable tendency to relapse. As other factors accounting for the advance in the number of admissions, may be mentioned: that the value and comfort of asylums are increasingly appreciated, that there has been a large number of patients transferred from work-houses to asylums, and that there has been an ever increasing encroachment on the mass of unregistered cases of insanity which the census has shown to exist. The apparent increase in the numbers of the insane have taken place among the poorer rather than the well-to-do classes of society. Although Dr. Tuke did not conclude that insanity is on the increase, he lamented the undoubted fact that it had not decreased, in spite of all the efforts of physicians and social reformers to improve the condition of the race.—*British Medical Journal.*

Contribution to the Etiology of General Paralysis.—DR. THEODOR KAES, in a recent report gives the following statistical information concerning the percentage of cases of general paralysis among the inmates of the Hamburg asylum. From January 1, 1870, to December 31, 1889, there were admitted to this asylum 9,148 patients, of whom 4,970 were males and 4,178 were females. Of this number, 1,412 suffered from general paralysis, or about 15.44 per cent. of the entire number; the percentage for males being 21.99 per cent. and for females 7.55 per cent. Among the patients who left the asylum during the same period, 22.74 per cent. of the men and 7.39 per cent. of the women were general paralytics. This would make the general average for both sexes 15.485 per cent.; for the males, 22.365 per cent. and for the females, 7.47 per cent. These statistics correspond very closely with those given by Prof. Mendel, as the collective statistics of German asylums. An important point in which the present writer differs from Mendel, is the proportion of males to females. Mendel gives the proportion as 5 to 1, while Kaes' observation shows a proportion of 3.44 to 1. Dr. Kaes also gives statistics showing that there has been an absolute as well as a relative increase in general paralysis in Hamburg from 1870 to 1890, the increase varying in different years. The most important factor in the etiology of the disease is, in his opinion, excess in taking stimulants; next to that heredity, syphilis, and tabes dorsalis. Head-injuries, acute infectious diseases, etc., which are often given as causes, he does not think have a very intimate etiological relationship. It would seem that in women the age of the patient is younger when the general paralysis first shows its development than it is in men, which is on account of the important part prostitution and alcoholic excesses play as etiological factors of the disease in women.—*Allg. Zeitschr. f. Psychiatrie*, Vol. xlix, No. 3.

Masked Epilepsy.—DR. ALEXANDER B. SHAW reports seven cases of masked epilepsy. In the first case, a nurse girl 16 years old, the attack consisted of sudden momentary muscular contractions, especially involving the extensors; a frightened look is present, and she invariably drops any article that she may be holding. Apparently there is no loss of consciousness. The second case, a child 3 years old, has attacks five or six times daily, during which she suddenly seizes any object near which she may chance to be; she becomes pale, rigid, and silent, and remains so for perhaps fifteen seconds, then draws a long, sobbing breath, and at once goes about her play. (When she was nearly 8 years old she had a well-marked epileptic fit, and has had one about every six months since that time.) The third case, a boy 5 years old, begins suddenly to stagger as if about to fall and says, "I can't see, I can't see;" he becomes covered with perspiration, insists on lying down, and goes to sleep immediately. (The attacks ceased to recur after he was about 9 years old.) The fourth case, a young man 17 years of age, is subject to sudden attacks of severe pain in the epigastric region, followed immediately by mental confusion lasting about two minutes, during which he answers yes to every question. He does not appear to be unconscious, but has no recollection of anything said by himself or others, or that occurred from the time he complained of the pain until with a sudden start he exclaims, "What's wrong?" or "What's the matter?"

On leaving his home to go to his father's store, which is about two miles away, he has on several occasions wandered off to some other part of the city, and suddenly becomes conscious of the fact that he was in a locality quite remote from that for which he had started. (Subsequently he had two well marked epileptic convulsions, with complete loss of consciousness.) The fifth case, a woman 36 years old, has for years been subject to attacks of lancinating pain in the left mammary region, lasting 30 to 60 minutes; after which she takes a few deep inspirations, of which she retains no recollection, becomes very drowsy for 10 to 15 minutes, after which she appears well. (This condition was followed by attacks of *grand mal* after several years' duration.) The sixth case, a man, was subject to attacks of maniacal excitement, of which he afterwards had no recollection. The last case occurred in a man 26 years of age. About two years ago he commenced to have seizures, beginning with pain in the lumbar region, gradually extending up to the occiput. Then the whole head would commence to pain him intensely; he would not fall but would suddenly become unconscious of having suffered, and would remain so for hours. In this condition he would at times request those about him to read to him, and would comment quite rationally on what was read or said. At other times he would become delirious, and even maniacal. Consciousness returned suddenly, and he would then feel dull and nervous, and could not recall anything that had been said or done from the time that the pain became so intense in his head. Of late the seizures have become more frequent, and the last one was followed by a delirium of a week's duration. The author closes his report by emphasizing the facts that a temporary paroxysm of insanity may replace the epileptic seizure, and that there is a variety of insanity characterized by many of the distinguishing physical manifestations of epilepsy in which there is no evidence of a previous epileptic seizure.—*Medical Review.*

Hereditary Degenerative Stigmata.—In a recent treatise on this subject, PROF. MAGNAN, of Paris, divides degenerative heredity into three classes. In the first, the intelligence of the subject is perfect but his moral state is defective; in the second class, the patient's moral state is perfect but certain intellectual aptitudes, or certain faculties, are entirely faulty; in the third class, the individuals are well balanced under ordinary circumstances, both intellectually and morally, but under slight depressing or fatiguing influences they show loss of mental equilibrium and intellectual and moral defections. Prof. Magnan cites, in conclusion, a peculiar case of sexual perversion, illustrating the idea of degenerative heredity: A young man, 21 years old, was observed one day to take a pair of scissors from his pocket and with them cut a large piece of skin from his left arm. When pressed for an explanation of this peculiar behavior, he said that he had spent many pleasant hours in pursuit of a young girl who had beautiful white skin, and when he saw her he was filled with a desire to kill her and eat her skin. In order to prevent himself from doing this, he turned his passion against himself and cut his own skin. The act of mutilation was accompanied with sexual erethism followed by a profound feeling of comfort and ease. In this case his antecedents were very bad. His paternal grandfather was an alcoholic, his father suffered from epilepsy and died from cerebral apoplexy. A sister of the patient is insane. The patient himself had been incorrigible from infancy. At the age of six the sight of a young boy or girl with a fine, delicate skin, would provoke sexual excitement. When nine years old he began to masturbate and had ejaculations, and at the moment of ejaculation it was his habit to prick deeply the abdomen with a pin, a knife, or the point of a sword. When he resisted the temptation to slay a child with beautiful skin, he had peculiar sensations of innervation and of dying, with a sensation of constriction and contraction in the epigastrium. When he experienced these sensations he would cut himself. The mental condition of the patient is variable; sometimes he is gay and happy, at other times he is haunted with the idea of suicide. Physically he has but few of the stigmata of degeneration.—*Arch. de Neurologie—Journal of Nervous and Mental Diseases.*

Some of the New Hypnotics for the Insane.—DR. GRANGER, in a paper read at a meeting of the New York Neurological Society, said that those drugs were the best hypnotics, which act first and strongest upon the cortex, dulling the sensibilities, and lessening voluntary muscular activity, and which influence but little the vascular system and blood pressure. Among the newer hypnotics he mentioned bromal hydrate; he said it was more dangerous than chloral and of but little value. Chloralamid he considered less depressing than chloral, although serious collapse had followed its use. It produces quiet and refreshing sleep with no unfavorable after effects. It is not so certain in its action as chloral, and it does not act so promptly. The dose is from 30 to 45 grains. It is useful as an alternative to the other hypnotics. Chloral-ammonium, in doses of from 15 to 30 grains, is said to be non-depressive, and considered a good hypnotic. Hypnal has the reputation of uniting the analgesic effects of antipyrin and the hypnotic effect of chloral. It is useful when sleeplessness and pain are combined and the employment of opium is contraindicated. The dose of the drug is from 15 to 30 grains. Urethan, which belongs to the ethyl group, is useful in the milder cases of insomnia, and for purposes of change. Its dose is from 20 to 40 grains. Somnal is an alcoholic solution of chloral and urethan, and of little value. The dose of somnal is 30 grains. Paraldehyde can not be classed among the newer drugs. It is the only drug, aside from chloralamid, which is comparable with chloral in hypnotic power. These three hypnotics are valuable in all cases of insomnia. Sulphate of duboisin is used as a substitute for hyoscin. It has been said to give more natural sleep and to be less depressing. Sulphonal, tetronal, and trional are so closely related that they may be considered together. The first mentioned has marked hypnotic power and seemed, in ordinary doses, to be safe. Its long continued use was, however, dangerous to health. Its action is often slow; it seems to be precipitated in the stomach, unless quickly absorbed. Its effect is frequently long-continued, the second dose often acting better than the first. It appears to be of little value where sleeplessness is associated with pain. Trional and tetronal are true hypnotics, but alike in many respects to sulphonal. They are all less powerful than chloral.

Transfusion of Nerve-matter in Cases of Insanity.—DR. CULLERRE has made about 500 injections, in cases of insanity, with a fluid prepared as follows: The cortical substance of a sheep's brain is macerated for 24 hours in a double quantity of pure glycerine, to which is added an equal quantity of boiled water, the fluid after filtration being about equal to a 20-per-cent. extract. Dr. Cullerre injected 4 gm. (fl ʒj) of this fluid, every two days, in the lumbo-dorsal region. Not one of the 500 injections was followed by unfavorable symptoms, not even when made on feeble patients. They seem to stimulate the functions of nutrition almost at once, one of the first indications of the stimulating effect being an almost insatiable appetite. In cases of insanity where the patient refuses all food, this effect of the injection would seem to be of value. In the course of the treatment, the patient increases in weight and gains in strength, and all organic functions become regular. In the curable cases, the mental condition improves at times, temporarily, just after the injection. A permanent improvement did not result; still, the author does not consider this question settled, as most of the cases experimented upon presented an unfavorable prognosis.—*Centralblatt f. klin. Medicin.*

Sudden Fatal Illness in Melancholia.—A patient, in whose family there was a history of neuropathy, was convalescing from a second attack of melancholia, when he suddenly presented a picture of severe shock and collapse. As the patient, during both attacks of the mental ailment, had been subject to hypochondriacal delusions, referable to his digestive organs, the symptoms were not considered so dangerous as they would have been under other circumstances. Thirty-five hours after the onset of the acute symptoms, death took place, and the *post-mortem* examination showed that it was caused by strangulation of the bowels. It was found that about three and one-half feet of the small intestine had passed through what appeared to be a congenital slit in the mesentery. The coëxistence of delusions and bodily ailment shows that frequently the former have real bodily causes for their foundation. It is possible that the intestines had always, or at least for some time, moved backwards and forwards through the congenital slit, and the discomfort and uneasy feelings thus produced, acting upon a hereditarily weak brain, had induced the mental illness. *Lancet—Journal of Nervous and Mental Diseases.*

FORMULÆ.

By Geo. B. Somers, M. D., San Francisco, Cal.

Diphtheria.—The following formulæ are highly recommended:

I. To disinfect the air (J. Lewis Smith):

(*a*) Ol. eucalypti	
Ac. carbolici	āā ℥i
Terebinthinæ	℥vii

S.—One tablespoonful to a quart of water and allowed to simer constantly near the patient.

(*b*) Modification of above by Dunmire:

Ol. cinnamomi	30 parts
Ol. eucalypti	180 parts
Acid. carbolici	220 parts
Ol. terebinth.	420 parts

S.—One ounce to a quart of water.

II. Local treatment (Grancher):

(*a*) Camphor	20 parts
Castor oil	15 parts
Alcohol	10 parts
Carbolic acid	5 parts
Tartaric acid	1 part

S.—Remove exudate and apply by means of cotton wrapped on a pincett.

(*b*) Papayotin or trypsin	gr. lxx
Corrosive sublimate	gr. ¼
Distilled water	ʒ iv

S.—Apply every half hour until the membrane is dissolved.

(*c*) Corrosive sublimate	1 part
Tartaric acid	5 parts
Water	1000 parts

S.—Wipe off the exudate with the above.

III. Constitutional.

Corrosive sublimate	gr. iss
Syrup of orange	
Water	āā ℥i

S.—One-half to one teaspoonful every six hours.—*Journal American Medical Association.*

Phosphate of Sodium.—CONSTANTIN PAUL considers this salt preferable in many cases to the sulphate of the same base. It is never attended by griping. As a simple solution it may be prepared as follows:

Phosphate of sodium	℥ i
Simple syrup	℥ ii
Essence of lemon	m xx
Distilled water	℥ viii

To obtain an effervescent solution, the following are added to the above formula:

Citric acid	
Sodium bicarbonate	āā ʒ ss

—*Medical Week.*

An Effective Depilatory.—BUTTE recommends iodine collodium, which for three or four consecutive days is spread rather thickly upon the spots. When the collodium is removed, the hairs will be found adhering to the under side:

Alcohol	ʒ iii
Iodine	gr. x
Collodium	℥ i
Oil turpentine	mxx
Castor oil	ʒ ss

—*Medicinische Monatschrift.*

Sciatica.—RICHARDSON gives the following as the most effective formula he has ever used for relieving the pain of sciatica, acute or subacute:

Pulv. opii pur.	gr. xii
Pulv. ipecac. ver.	gr. xii
Sodæ salicylatis	ʒ ss
Ext. cascaræ sag.	q. s

Fiant pilulæ duodecim

S.—One or two to be taken for a dose, as directed. This pill induces action of the skin, relieves pain, and keeps the bowels free.—*Asclepiad.*

Gastric Troubles in Neurasthenic Patients:

Phosphide of zinc	gr. ii
Bromide of zinc	gr. xx
Bromohydrate of quinine	gr. xxx
Extract of nux vomica	gr. iii

Divide into 30 pills. Three daily.—*Medical Press and Circular,*

Fermentative Dyspepsia.—B. W. RICHARDSON recommends the following where there is acid eructation, distension, and "heart-burn:"

Ol. creasoti pur	mxii
Sp. tenuosis	℥ iiss
Am. benzoatis	ʒ ii
Glycerini pur.	ʒ vi
Infus. caryophylli	*ad* ℥ vi

S.—Half a fluid ounce to be taken in four ounces of water as directed.

The dose is usually taken between meals, two or three times a day. If the acidity is considerable, a little alkali—potassa is best—can be added with each dose, or as occasion may require.—*Asclepiad.*

Compound Antiseptic.—The following combination, published in the *Annals of the Partem Institute*, is said to be equal to the bichloride, and without its objectionable features:

Carbolic acid	gr. 135
Salicylic acid	gr. 15
Lactic acid	gr. 30
Menthol	gr. 1½

—*Progres Médical.*

Vaginismus.—DE SINCTY prescribes:

Thymol	gr. iii
Ext. of belladonna	gr. xii
Bromide of potash	ʒ ss
Cocoa butter	ʒ iv

For four suppositories. One when needed.—*Medical Record.*

Pneumonia.—In St. Francis Hospital, New York, the following formula is used:

Tr. aconiti	mxxiv
Tr. opii camph.	ʒ ii
Liq. ammonii acet.	
Syr. zingiberis	āā ℥ ss
Aquam	*ad* ℥ vi

S.—Half ounce every two hours.—*Medical Record.*

Facial Neuralgia:

Sulphate of quinine	
Dover's powder	āā gr. ii
Ext. of valeria	q. s

For one pill. Four daily. Seldom fails.—*Medical Press and Circular.*

Diuretic Wine, for edema, general anasarca, and dropsy, in cardiac and renal diseases:

Fluid extract of jalap	ʒ iii
Fluid extract of squills	ʒ iii
Fluid extract of jaborandi	℥ i
Fluid extract of digitalis	mxxx
Nitrate of potash (pulv.)	ʒ iv
Angelica wine	Oii

S.—One tablespoonful every three hours. —*Virginia Medical Monthly.*

Acne Rosacea.—PETRINI in *Roumaine Médicale* recommends:

Flexible collodion	30 parts.
Ichthyol	2 parts.
Resorcin	1 part.

S.—Paint on the diseased parts for three days, all pustules having been previously opened. Repeat the applications after five or six days.—*American Journal of Medical Sciences.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for January, 1894.—The deaths registered in 97 town districts of the State, during the month of January, in a population of 832,651, correspond to an annual rate of 17.76 a thousand, the total mortality having been 1,238. 78 deaths were due to zymotic diseases, giving an annual rate of 1.116 a thousand. Of these, 19 were due to diphtheria, 2 to cholera infantum, 28 to typhoid fever, 1 to diarrhea and dysentery, 0 to cerebro-spinal fever, 14 to whooping cough, 10 to croup, 4 to intermittent and remittent fevers, 0 to scarlet fever, 0 to measles, and 0 to small-pox. 375 deaths resulted from diseases of the respiratory organs, giving an annual rate of 5.52 a thousand. Of these, 209 were due to consumption, 113 to pneumonia, 44 to bronchitis, and 9 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.88 and 1.56, respectively. 115 deaths resulted from diseases of the heart, 7 from alcoholism, 5 from erysipelas, 37 from cancer, and 552 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 581,653, was 19.2. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Berkeley.

METEOROLOGY.

Summary for January.—*Temperature.*—The normal temperature of the State for January is 46°, the average for January, 1894, was 45°; a departure from the normal of 1°. The highest monthly mean was 54°, at Indio, in the desert regions of San Diego county, 200 feet below sea level; the lowest, 23° at Truckee, in the mountain regions of Nevada county, 5,819 feet above sea level. The maximum temperature was 83°, at Indio on the 28th; the minimum, 22° below zero, at Boca, Nevada county (5,531 feet above sea level), on the 6th. The greatest monthly range was 61°, at Tehachapi; the least, 18°, at Point Lobos.

Rainfall.—The normal precipitation for the State for January is 4.52 inches; the average for January, 1894, was 5.03 inches; a departure from the normal of +0.51 inches. The greatest monthly precipitation was 27.56 inches, at Upper Mattole; the least, a trace or sprinkle, at Keeler.

Wind.—The prevailing direction of wind was westerly.

Unusual Features.—The unusual meteorological feature of the month was the continued low temperature in Southern California.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for January, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn ....Cal.	46.0	75.0	25.0	------	------	------	----	6.96	------	----	----	----	S.W.	Southern Pacific Company.
Berkeley......... "	44 0	59.0	31.0	51.0	41.0	10.0	12	9.54	88 0	11	6	14	S.E.	Obs. University of California.
Colfax........... "	39.0	60.0	20.0	------	------	------	----	13.40	------	----	----	----	S.E.	Southern Pacific Company.
Eureka.......... "	46.0	59.0	28.0	50.0	41.0	9.0	19	12.38	94.0	3	4	24	S.E.	Weather Bureau Dept. Agr.
Fresno........... "	44.0	64.0	25.0	52.0	36.0	16.0	12	2.27	79.0	7	9	15	N.W.	" " "
Keeler........... "	38.0	64.0	15.0	48.0	28.0	20.0	2	T.	42.0	24	6	1	E.	" " "
Los Angeles.... "	51.0	75.0	32.0	62.0	40.0	22.0	5	0.94	70 0	21	6	4	W.	" " "
Monterey .... "	46.0	60.0	26 0	------	------	------	----	3.25	------	----	----	----	S.	Southern Pacific Company.
Napa........... "	47.0	60 0	30.0	54.0	40.0	14 0	12	8.17	82.0	8	10	13	S.	Station Napa Insane Asylum.
Oakland......... "	45 0	58.0	29 0	52 0	41.0	11.0	14	9 02	96.0	17	6	8	N.W.	Chabot Observatory.
Paso Robles.... "	42.0	63.0	19.0	53.0	31.0	22.0	6	1.06	63 0	12	11	8	N.	Agricult. Experiment. Stat'n.
Red Bluff....... "	42 0	59.0	27.0	49.0	36.0	13.0	14	5.29	86.0	7	15	9	N.W.	Weather Bureau Dept. Agr.
Sacramento. ... "	44.0	58.0	26.0	51.0	37.0	14.0	12	4.17	85.0	8	11	12	S.E.	" " "
San Bernardino "	47.0	74.0	23 0	60 0	34.0	26.0	5	1.26	68.0	22	3	6	W.	A. K. Johnson, M. D
San Diego....... "	50.0	69.0	32.0	58 0	42.0	16.0	4	0 29	74.0	14	15	2	N.W.	Weather Bureau Dept. Agr.
San Francisco.. "	48.0	58 0	36.0	53.0	43 0	10.0	14	5.99	82.0	9	12	10	N.W.	" " "
Santa Barbara.. "	50.0	70.0	33.0	59.0	41.0	18 0	5	0 99	69.0	24	1	6	W.	Hugh D. Vail.
Santa Cruz...... "	49 0	65.0	27.0	59.0	39.0	20.0	8	7.02	------	20	8	3	S.W.	W. R. Springer.
Yuma...........A. T.	52 0	74 0	28.0	65.0	38 0	27 0	0	0.00	49.0	24	6	1	N.	Weather Bureau Dept. Agr.

T. means a trace of rain. Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: MARCH, 1894.

THE NEED OF A BETTER PROFESSIONAL ORGANIZATION.

The approaching meeting of the American Medical Association has, already, had a marked effect in stimulating the organization of medical societies and the reorganization of those formerly in existence. California is not backward in the matter of professional organization, yet much remains to be done ere it can claim that even a fair measure of success has been attained. We need more local societies and more active and practical work amongst those already in existence. Here and there the good work is being carried on, but the effort should be more general, and a majority of the counties should have active societies, meeting at regular intervals. The State Society, while perhaps as fairly representative of its constituency as any similar organization, is, in numerical strength, far below the standard that might be expected. According to the last Medical Register, the total number of physicians practising in the State was 2,101, while the membership of the State Society, according to the roll of the last annual volume is only 363.

With this organization, however, a more hopeful view is possible, for of late years its growth has been steady, and the increase, though small, has been very perceptible. This increase has been more marked since the policy of centralization, so long in force, has been abandoned. As the Society meets in different sections, it gathers in the profession in the vicinity of the place of meeting, and while some inevitably drop out, the permanent gain is considerable. The approaching meeting of the State Society should see a boom in its membership that has not been experienced in years. The State has been thoroughly canvassed, not only by the Committee of Arrangements of the Society, but also by the Committee of the American Medical Association. The advantages of membership and the coming of the Association have been fully set forth; this, with the presence of the Midwinter Fair within an hour's ride of San Jose, and the prevailing low rates of transportation, should insure a large attendance.

The Local Society, we have always maintained, is the strongest factor, as well as the most important, in our organization. Here the greatest good and the most direct benefit is obtainable by membership. Men meet on the intimate footing of personal association, learning to know each other better and gathering information by an interchange of personal experience that is doubly valuable because acquired in the same environment. Discussions impossible in larger bodies can here be conducted and with far greater profit to the participators. Difficulties that arise in every-day life can be adjusted, and those who ignorantly or wilfully stray from the paths of rectitude, can be shown the error of their ways and be encouraged to reform.

NOTES.

Mathew's Medical Quarterly.

The first number of this journal has made its appearance. It is a substantial magazine of 190 pages, 134 of which are original matter. The material of this issue is undeniably good, and the general make-up of the journal, if maintained, will place it upon a sure foundation as a literary venture.

San Joaquin County Medical Society.

We have much pleasure in stating that the San Joaquin County Medical Society has been reörganized. Dr. A. W. Hoisholt has been elected President, and Dr. C. R. Harry, Secretary. This may be taken as an evidence of the quickening power of the American Medical Association, the approaching meeting of which is already bearing fruit. We hope, from time to time, to present the work of this Society to our readers.

A Supplement to the Sixth Edition of the Medical Register.

This volume, which bears the rather ponderous title of "Supplement to the Sixth Edition of the Official Register and Directory of Physicians and Surgeons in the State of California," has just been issued by the Board of Examiners. It is really a new register, including only the "county lists." This makes a small and compact volume, renders it possible to have a revised Register at shorter intervals, and, as the new licentiates also appear in the regular form at the commencement of the book, the system of reference is maintained complete. The locations of practitioners have been made as accurate as possible, and where errors occur it must be charged to the individual, or, perhaps, to the local correspondent of the Board. The Medical Register has now become invaluable to the profession, and advances of this character will be warmly welcomed. We have but one criticism to make, namely, to regret the appearance in the body of the book of *any* advertising matter. This little unpleasantness is one that can easily be rectified.

Rush Medical College to Require Four Years' Attendance.

In pursuance of the policy recently announced in the resolution to be presented to the American Medical College Association, the Trustees and Faculty of Rush Medical College have decided to require four years' attendance at College, from students who begin the study of medicine this year with a view to graduating in 1898; however, those who have already studied medicine one year or more with a preceptor, so that the four years of study, already required, will be completed before July, 1897, may graduate after three courses of lectures, as heretofore. To encourage proper preliminary study, graduates in arts and sciences from high grade colleges and graduates in pharmacy and dentistry from colleges requiring a proper amount of study and two full courses of lectures will, until further notice, be allowed to graduate after an attendance on only three courses of lectures.

California Northern District Medical Society.

The California Northern District Medical Society will hold its semi-anual meeting at Woodland, on Tuesday, March 13. An interesting program has been prepared, and the northern counties promise a large attendance. This meeting has a special importance from the fact that the near approach of the meeting of the American Medical Association provides an incentive for joining the District Society to those in whose vicinity there is no local society. The following are the titles of papers, with the names of the authors as well as some of those who will open discussions on the subjects given: "A Case of Procursive Epilepsy," A. W. Hoisholt, Stockton, Elmer E. Stone, Marysville; "Diphtheria," Oscar Stansbury, Chico, C. H. Gibbons, Arbuckle; "Gastric Ulcer," W. E. Bates, Davisville, B. Caldwell, Biggs; "The Decline of Maternity," David Powell, Marysville, J. H. Parkinson, Sacramento; "The Foothills of the Sierra Nevada Mountains in the Climatic Treatment of Bronchial and of Pulmonary Affections," R. F. Rooney, Auburn, J. R. Laine, Sacramento; "The Causes and Treatment of Abortion," W. R. Cleaveland, Biggs, Thomas Ross, Sacramento; "Some Peculiar Effects of *La Grippe*," H. D. Lawhead, Woodland; "The Treatment of Gonorrhea by Retro-Injections," W. J. Hanna, Sacramento. After the adjournment of the meeting a banquet will be tendered the visitors by the Yolo County Medical Society, at Byrne's Hotel. H. D. Lawhead is Chairman of the Committee of Arrangements.

AMERICAN MEDICAL ASSOCIATION.

Membership in the American Medical Association.—"This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues and subscription for the *Journal.* Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly *Journal* of the Association will be forwarded regularly."

Application Blanks for Membership.—On advertising page xxvii we print a convenient form of application blank that is being circulated by the Association *Journal,* Any physician desirous of joining the Association can cut out this blank, and, having properly filled it, can mail same with his subscription to the Treasurer. As many physicians seem to be waiting for these blanks before joining the Association, it is pertinent to remark that the blank is not a necessity but merely a convenience. The essential is a certificate signed by the President and Secretary of a State or local Medical Society, and this, accompanied by $5, will be duly honored by the Treasurer. Meanwhile our readers will find each month the regular application form in our advertising columns, and we shall be at all times ready to afford any information in these matters.

The Payment of Dues in the Association.—Inquiry has been made as to the liability of members for the annual dues of the Association. At each annual meeting members, when registering, are required to deposit $5.00 annual dues, for which the Treasurer's receipt is subsequently issued. The point in doubt has been: What is the position of the man who has joined shortly preceding an annual meeting, at which time the fiscal year of the Association begins? Dr. R. J. Dunglison, the Treasurer, furnishes the following statement, which makes the matter quite clear: " Every new or old member pays dues but once a year. At the annual meeting all that it is necessary for him to do is to produce the Treasurer's receipt, instead of paying money, when he registers. For instance, if he pays in May, as a member by application, his membership is covered by such payment until the following May. This also applies to all dues paid in advance for the fiscal year 1894, which begins with the annual meeting in San Francisco. Any one who may accidentally duplicate his payment will be given credit for the same for the next coming year, or have the amount refunded by Treasurer." There is, therefore, no object in those contemplating membership waiting for the meeting of the Association to join. They can do so at any time, having, meanwhile, the advantage of the Association *Journal,* which they will receive weekly. It may here, incidentally, be remarked that at the time of the annual meeting it is very desirable that members register at as early a date as possible, so as to avoid the inevitable rush of the first day.

Committee of Arrangements.—DR. R. H. PLUMMER, Chairman of the Committee of Arrangements, has appointed the following as an Executive or Central Committee: W. Watt Kerr, W. R. Cluness, W. S. Thorne, C. E. Blake[1], R. A. McLean, J. Rosenstirn, H. Gibbons, Jr., J. H. Parkinson, and R. L. Rigdon. This may be regarded as a fairly representative committee. Dr. Kerr is the permanent Secretary of the State Society, and is also President of the San Francisco County Medical Society. Dr. Cluness and Dr. Thorne are ex-Presidents of the State Society. Dr. McLean is the Dean of the Medical Department of the University of California, and Dr. Gibbons fills the same office in Cooper Medical College. It is of interest to mention that Dr. Cluness, Dr. Thorne, and Dr. Gibbons were present at the meeting of the Association in San Francisco in 1871, becoming members at that date. The committee organized by electing Dr. Rigdon as its Secretary, and has matters well under way. The untimely death of Dr. C. E. Blake, has deprived it of one who was ever ready to assist in all that promised well for the advancement of our profession.

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[1] Since deceased.

Place of Meeting.—The Committee of Arrangements has secured Odd Fellows' Hall, corner Market and Seventh streets, as the place of meeting for the general sessions and the sections. This building furnishes one large hall with a seating capacity of 1,500, and twelve halls that can accommodate from 500 to 100 persons. There are also committee rooms in the building. This enables all the Association work to be carried on under the same roof, a very desirable feature that has not always been possible in other cities. It permits members to be present at different section meetings on the same day with the least possible loss of time, and by this concentration will tend to prevent stragglers. The acoustic properties of the main hall are good, and there is a large gallery for the accommodation of visitors.

The Exhibition.—The exhibition will be held on the ground floor of the same building, in a large room that the Odd Fellows use as a banquet hall. Ample space has been provided, but at the rate at which it is being taken up there will soon be none left for disposal. The fact of the exhibition being in the same building with *all* the meetings of the Association, is an advantage that has been quickly realized by the intelligent business man, and this feature will be on a par with any that have, so far, been held.

Headquarters.—The headquarters of the Association will be at the Palace Hotel, corner Market and new Montgomery streets. It is, therefore, on the same street and just four blocks from the place of meeting. It should be mentioned that the whole of the Market-street system of cable cars traverses these four blocks—the Hayes, Castro, Valencia, and McAllister street lines coming into Market street at Odd Fellows' Hall. This provides a car each way every few seconds, a service that is certainly not surpassed in any American city. The Registration Bureau, Association Postoffice, etc., will be in Marble Hall, close to the hotel vestibule, and committees will meet in Parlor A on the first floor. One of the many features of the Palace is its central covered court, which will make it pleasant for the ladies when going to or coming from the different entertainments.

Railroad Rates.—We had hoped ere this to publish some definite statement regarding railroad rates. This, however, has been impossible owing to the disturbed conditions at present prevailing amongst the transportation companies. It is fairly certain that the present "Midwinter Fair Rates" will be available for the Association, and that the privileges there accorded will be extended so as to cover a period amply sufficient to take in some of the State. Just at present a rate war is in progress, which, should it continue, may reduce fares to any point short of zero. It is, however, unlikely that this suicidal policy will prevail for long, and the Fair rates may be taken as a basis for figuring. Excursion rates throughout the State are now in force, and will be available for members. These give substantial reductions. Members from abroad should bear in mind that the lowest rates frequently do not provide for stop-over privileges, and that round-trip tickets purchased over a desirable route will enable a large amount of sight-seeing to be done without additional expenditure for transportation.

Nebraska Excursion.—Dr. Wilkinson, the editor of the Omaha *Clinic*, is organizing an excursion for his State, and will "personally conduct" it. This excursion will go first to Denver and thence, over the Union Pacific, to Salt Lake, to ultimately pass through Sacramento. It now looks as if those who "gave up the case," and predicted the cold and clammy death of the Association on the Pacific Coast, will have the mortification of seeing the case "in the hands of other physicians," and the Association strengthened by an accession of membership that will surpass the most sanguine expectations and effectually squelch malignant criticism.

The Association and the Midwinter Fair.—A serious error in the relationship of the Association to the Midwinter Fair recently obtained publicity in the columns of the San Francisco *Examiner*. It was there made to appear that the Association meeting was being held under the auspices of the Midwinter Fair. The mistake was, no doubt, unintentional, but it cannot be too emphatically corrected. When the prevailing character of the "Medical Congresses" at the World's Fair is recollected, it will readily be seen that an error of this kind might seriously interfere with the success of the meeting. In the first place, the American Medical Association meets under the auspices of the medical profession of the State in which the meeting is held. In the next, the Association had decided to go to San Francisco before the preliminary organization of the Midwinter Fair had been effected. The Fair is a very important item in our list of attractions, and will, no doubt, be a strong drawing card, but with this the matter abruptly ends.

Association Train.—The Association train will leave Chicago, Monday, May 28, via Santa Fé R. R., Denver & Western, and Southern Pacific, for San Francisco, via Denver, Colorado Springs, Leadville, Manitou, Glenwood Springs, Salt Lake, Ogden, Truckee and Sacramento. Returning, after the meeting, the train will pass through Sacramento and northern California to Portland, thence east, by way of the Northern Pacific R. R., to St. Paul. A stop-over at Yellowstone National Park, for those who desire it, has been arranged, and it is understood that at several places on the journey there will be short stops. President Hibberd's party, in a special car, join the train at Chicago, and the St. Louis party are expected to join at Kansas City. From all points east and south, concentration on this train should be effected at Chicago and St. Louis.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, January 23, 1894.

The President, F. L. Atkinson, M.D., in the Chair.

New Member.—G. M. Ogden, M.D., was duly elected a member of the Society.

Nephrectomy—Fracture and Dislocation of Cervical Vertebræ.—Dr. G. A. White reported two cases of nephritic abscess. In the first case, the patient died from septicemia. In the second case, the kidney was removed and the patient died from shock. This kidney was tubercular. It was removed through the loin without injury to the peritoneum. The specimens from three cases of broken neck were also exhibited. The speaker said they were interesting from a medico-legal standpoint, as the question was often asked in court, "How long can a man live with a broken neck?" The first case was that of a fracture of the fifth cervical vertebra. The body was incompletely paralyzed, loss of sensation and motion coming on gradually. Constant priapism was a symptom in this case. The patient died on the second day. The second case was one of dislocation of the axis from a blow on the back of the head. Death was instantaneous. The injury was identical to that produced from hanging. The third case was one of fracture of the seventh cervical and first dorsal vertebra, due to a gunshot wound. There was complete paralysis of the extremities, yet the patient was able to rise upon his elbows. He died upon the day following the injury, the paralysis gradually extending upwards.

Dr. G. L. Simmons read a paper on "The Sacramento Society for Medical Improvement." The history of the inception and organization of the Society, and some of the events of its earlier life, were briefly reviewed. The influence of the Society upon the medical history of the State was mentioned, as well as the more prominent events in which it had taken an active part. A list of its distinguished members, some of whom were now resident elsewhere, and many that had passed away, was given, and the hope was expressed that its scope of usefulness would widen in future years. Some suggestions as to the advisability of enlarging the fee-bill, so as to provide a minimum fee for all ordinary operations, were offered, and the opinion expressed that the Society should defend its members in cases of action for malpractice.

Dr. H. L. Nichols, in opening the discussion, said the paper had interested him deeply, as he was one of three surviving charter members. It was very agreeable to him to hear these reminiscences of early years.

Dr. J. H. Parkinson: It is exceedingly desirable that the history of our Society should be preserved, and we are especially fortunate in having a member who has the facts in his possession. We have the earliest medical organization in the State, and it was due to the efforts of a member of this Society that the State Society was reörganized. This Society has done quite as much as any organization in the State, and Sacramento has been considered a stronghold of regular medicine.

Dr. Thos. Ross endorsed the statements of the author in regard to the amount of good the Society had done. The paper had brought up reminiscences which were very pleasant.

Dr. W. A. Briggs recalled an incident that occurred four years ago at a banquet, at which time Dr. Simmons was requested to write, at his leisure, a history of this Society. He intended to make a motion, at the proper time, in regard to the matter.

Dr. C. B. Nichols: This paper recalls to me an article which described the meeting of a society which had celebrated its one-hundredth anniversary; they had collected a history of its members which was very interesting. We might do the same, and it would be pleasant and valuable to refer back to them in time to come. The fact of making the fee-bill more complete would prevent any misunderstanding. All operations should have a fee attached which might be regarded as a standard.

Dr. W. E. Briggs: I formerly considered myself one of the younger members of the Society, but now I am beginning to feel as though I were one of its older members. I am proud of the fact that I am a member of the Sacramento Society for Medical Improvement; as the good work it has done is known all over the State and is appreciated by the rest of the profession. Our success is due to the fact that we meet regularly; there is no formality, and there is no occasion for censure. We find that a great many things which are said about each other are not true, and we learn to know each other better.

Dr. J. R. Laine: I cannot allow the paper to go by without some word of commendation. I have always been impressed with the smoothness of the work of our Society. The secret of its cohesive property is due to its simplicity and also to its social feature. Placing our legs under the same festive board brings us closer together, and we learn to know each other better. The recommendation as to the saving of specimens is a very good one, and I think a museum should be established. It would be but a short time before an extensive collection would be obtained. With regard to a fee-bill there should be extreme latitude. A man who is able should be made to pay quite liberally. There should be a fee-bill strong enough to enable us to collect a bill against an estate. The Society should take steps to defend its members against malpractice suits. It is better to do this under cover and refer it to a committee, thus avoiding any criticism.

DR. H. D. LAWHEAD, of Woodland: I am forcibly impressed with the growth of this Society. It seems to be just what the older members anticipated, and I think it is largely due to its simple organization. In regard to a fee-bill, we have no way of doing in the country except to do a $50 piece of work and charge $25. I think we should make charges and tell our patients that operations are worth so much. When a country physician visits one of your meetings, it shows him that progress is possible, and on behalf of my fellow practitioners, I would be pleased to see the paper published.

California Northern District Medical Society.—DR. H. D. LAWHEAD, of Woodland, the Chairman of the Committee of Arrangements, spoke at some length of the semi-annual meeting of this Society, especially in connection with the approaching visit of the American Medical Association. He extended a very hearty invitation to the Sacramento Medical Society, and hoped that there would be a large attendance from the Capital city.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, February 13, 1894.

The President, W. WATT KERR, M.D., in the chair.

New Member.—P. K. BROWN, M.D., was duly elected a member of the Society.

Dr. Charles E. Blake.—The committee appointed on resolutions on the death of Dr. Blake submitted the following:

WHEREAS, It becomes our sad duty to chronicle the sudden death of Dr. Chas. E. Blake, while yet in the prime of life and usefulness; and whereas, this Society recognized him as a valued member, an intelligent, qualified, and capable practitioner, a respected citizen, and a high-minded gentleman, whose kindly disposition, modest manner, and conscientious regard for duty endeared him alike to patient and to brother practitioner; and whereas, it is fitting that due expression shall be given to this, our appreciation of the man and the physician; therefore,

Resolved, That the San Francisco County Medical Society, while thus giving expression of its appreciation of his worth, deplores the untimely loss of its honored fellow member, Dr. Charles E. Blake, and tenders sincere and heartfelt sympathy to his bereaved family.

Resolved, That a copy of this preamble and resolution be transmitted to the family of the deceased, and that they be spread in full upon the minute-book of this Society.

JNO. WAGNER,
C. G. KENYON,
HENRY GIBBONS, JR.,
GEO. CHISMORE,
C. C. WADSWORTH,
Committee.

Gynecology at the German Hospital in 1893.—DR. H. KREUTZMANN read a paper on this subject. During the year 1893 there had been 73 operations done on 60 patients. Curettment of the uterus and trachelorraphy, or removal of ovary and ventro-fixation, were included as done at one *séance*, though counted as two operations. A list of the operations accompanied the paper. Plastic operations on the perineum were done by the flap-splitting method. For total laceration he thinks the Tait method is unsurpassed; it is simple in execution and safe in result. It always gives some improvement, and admits of further operations. It is also useful in moderate lacerations, but in case of rectocele or cystocele a denuding operation is preferable. In cases of excision of the cervix, lacerations and a thick patulous cervix were always present. The operation was done in the usual way, a wedge-shaped piece of the cervix being excised from the anterior lip, the vaginal and cervical mucous membranes, and the cut surfaces being united with sutures. This operation seems to reduce the cervix, as well as to give relief to the subinvoluted uterus. The os remains patulous, and is much better than the pin-hole os in Emmet's operation. He did the operation several times at the request of women who knew that the womb was torn. Once possessed of this idea it haunts the sufferer day and night until an operation has been performed. No one doubts the moral effect and suggestive power of an operation on patients with functional nervous disturbance. In one case he made an incision, under ether, in a patient anxious to have her ovaries removed for some imaginary ache or pain. She was kept in bed for three weeks, and told that she must expect to menstruate again. The result has been complete amelioration of symptoms. The attention of the modern gynecologist has been turned from the ovary to the uterus, especially the retroflexed uterus. It has been attached from all sides, but three operations, vagino-fixation, ventro-fixation, and shortening of the round ligaments, are principally in vogue. Dr. Schuerkin, of Pyrmont, Germany, first fixed the uterus to the peritoneum of the plica vesico-uterinæ by means of a needle specially devised for the purpose. It is passed from the uterine cavity into the vagina, the bladder being pushed aside with a catheter. The suture is of silk. Prof. Zweifel improves this by separating the bladder from the uterus, making a transverse incision through the anterior vaginal vault, as in total vaginal extirpation of the uterus. Drs. Markenrodt and Duhrsen have further improved the *technique* by introducing the ligature from the vagina. Markenrodt first dissects the bladder from the vagina, and then from the uterus, and carries the threads from the vagina through the uterus, emerging on the other side into the vagina. With care the peritoneal cavity can be avoided. These stitches are subsequently removed. Duhrsen separates the bladder and uterus after Zweifel's method; pulls the fundus uteri well down, carries the threads through the peritoneal cavity high up in the fundus, fastens them on the inside of the vaginal flap, and tightening them brings the fundus directly out on the vagina. He buries the sutures in closing the transverse vaginal incision. He tried Markenrodt's operation in two cases and partly failed, the uterus being retroverted. Duhrsen's *technique* seems objectionable because the needle and sutures go through part of the abdominal cavity beyond the control of the eye, and buried sutures are apt to work their way into the bladder, giving rise to calculi. He had not shortened the round ligaments, but favorable reports have been made in that operation. Many women have retroflexed uteri without symptoms or complaints till informed of the trouble. In other cases some disease of other genital organs is the thing needing treatment—a pessary perhaps, being all sufficient for the retroflexion. Ordinary retroflexions require surgical measures only in exceptional cases, vagino-fixation or shortening of round ligaments. In complicated cases, opening the abdomen with ventro-fixation seems proper. In one of my cases I removed a kystoma ovarii, in another a diseased ovary, followed by the ventro-fixation of the uterus. Including my three cases of ventro-fixation, the abdomen was opened 28 times; sometimes giving a diagnosis different from previous opinions. One such case proved to be a nephritic instead of an ovarian tumor. It extended from border of ribs down into the pelvis (left side). The abdomen was opened four times and closed, because the condition proved to be inoperable on account of malignancy or otherwise. The ovariotomies included dermoid cyst, cysts of both ovaries, a double large multi-locular cyst, with a large fibromatous uterus, and one of cyst with carcinoma uteri. Seven patients died out of 83 located—60 operated upon. In four of these, malignant disease was the cause of death. One, I believe, died as a result of ether, three days after the operation. She had a slight cough, and from past experience I am much afraid of ether in such cases. I think it is a fallacy that chloroform is more dangerous than ether. I sincerely believe that in the same number of narcoses more fatal results are due to ether than to chloroform. Chloroform is more dangerous during operation. It requires more skill and attention. My other two deaths resulted from abdominal section. The case of nephrectomy succumbed to septic purulent peritonitis on the eighth day.

DR. F. W. VOWINCKEL thought Dr. Kreutzmann was in error regarding Markenrodt's putting stitches through the plica vesico-uterinæ. The speaker's impression was that silk sutures, passed through the central orifice, were used; these penetrated the vaginal wall and were tied in the vagina. The stitches were removed in five to seven weeks. The results were generally good in either procedure, but that of Duhrsen was less troublesome in its after-management. Personally, he had no fear of chloroform in heart lesions.

Dr. John Wagner said his experience showed that for practical results ether was superior to chloroform.

Dr. J. Rosenstirn said he had three cases of ventro-fixation of two years' standing, and there had been no relapse. He never operated except in retroflexions with adhesions, in which cases he thought vagino-fixation was of no use. As an anesthetic, he had, of late, come to prefer ether. He would choose chloroform in bronchial troubles and in aneurisms. The German reports were in favor of ether.

Dr. C. A. von Hoffman said the existence of a variety of operations indicated that there were no perfect methods. He believed operations were done too often. Emmet says the pinhole os is the fault of the operator. On the other hand, the wedge-shaped operation was as good as Emmet's. As an anesthetic he preferred chloroform.

Dr. M. Krotoszyner said he had seen results in Berlin, quite lately, showing that vesical incrustations and calculi were the results of sutures in the bladder. Duhrsen's operation was easily done; it did not present any special difficulties. Ether was more frequently used in the German hospitals. Some prefer to begin with chloroform and then continue with ether. The after effects of the latter were more unpleasant.

Dr. C. F. Buckley inquired what kind of pessaries Dr. Rosenstirn relied on to cure retroversion.

Dr. Rosenstirn disclaimed the statement that a cure was effected, but that only the symptoms were greatly ameliorated.

Dr. M. C. O'Toole mentioned the experience of an English operator who always gave whisky 10 minutes before an operation and who, in 500 cases, had not had an unpleasant result.

Dr. Kreutzmann, in replying, said: Markenrodt does not penetrate the peritoneal cavity, while Duhrsen does. He believed Emmet always reduced the cervical enlargement, erosions, etc., before operating surgically. Regarding the choice of an anesthetic, having had two deaths from ether, he was prejudiced against its use.

American Mutual Aid Association.—Dr. F. W. D'Evelyn called the attention of the Society to a leaflet that had been circulated in the city, attached to which were the names of several members of the Society. The document was referred to the Committee on Ethics, who were instructed to make a thorough investigation of this and other alleged attempts at violation of professional ethics and conduct, and to report at an early date.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, January 20, 1894.

The President, J. F. Morse, M.D., in the Chair.

Election of Officers.—The following were elected officers for the ensuing year:

President .... John F. Morse
Secretary .... John M. Williamson
Treasurer .... L. B. S. Pawlicki
Executive Committee..M. J. Fottrell, Wm. A. Martin, Theo. C. Rethers
Finance Committee......L. B. S. Pawlicki, Luke Robinson, W. S. Thorne

Dr. D. D. Crowley, of Oakland, read a paper entitled "Trephining for Epilepsy" [published at p. 122].

Dr. G. F. Shiels said: In view of the fact that I have lately trephined over the fissure of Rolando three times for general epilepsy, the paper of Dr. Crowley particularly interests me. The cases were of idiopathic general epilepsy, and not that due to injury. The first case was that of a man 32 years of age, on whom I operated a year ago last April. The fits were frequent, four to six occurring every day, and so violent as to cause the patient to stop his work. One day he fell in a fit and was subsequently placed under my care. In operating, chloroform was given, a piece of bone removed over the fissure of Rolando, and the dura was pricked with a needle frequently all over the exposed surface. The recovery was uneventful, no more fits occurring. The man went to the Arctic and worked hard. Returning to this city, he secured employment in a cannery. In the meantime another case came under my care, and was, if anything, worse than the first. Violent symptoms would set in and the patient would become maniacal. This case was operated upon in the same manner, and a good recovery made. For three months there were no fits, then the patient went to Germany. I had just written up these cases when in came the first man operated on, who reported that after an absolute freedom from fits for over year, they had now returned and were more violent than ever, he having had three that day. In the meantime a newspaper man had gotten hold of the case and calling it "Needles in the Brain," published it in one of the daily papers. It fell under the notice of a man from Oakland, who came to me for operation. I did not care to operate, but the man demanded it, so I did so. The case went along nicely for a week, when the patient became a raving maniac. I do not consider that there is any more benefit in trephining for epilepsy than there is from any other operation. We all know that frequently, after operating on epileptics, there is a stoppage of the attacks for some time, but it is almost sure to occur again. At any rate, that has been my experience in operations on general epileptics. Of course if there is jacksonian epilepsy and a traumatic history, we can locate and trephine as indicated. Certainly an operation in idiopathic epilepsy is of some benefit; for instance, in the first case the man had a year of useful life. This teaches us that the cause of epilepsy lies deeper than the surface of the brain. In all probability it is a systemic condition. These remarks do not apply to traumatic epilepsy, or in cases where abscess may be found.

Dr. Crowley: As to the merits of operating for the cure of non-traumatic epilepsy I cannot say. My paper was intended more to show the effects of the pressure of pus and granulations on the brain than with reference to the cure of epilepsy. In my case, five days after operation the power of articulation and the memory of words returned. In spite of what Dr. Shiels says, I believe that trephining does good in non-traumatic epilepsy, if the diet and general mode of living are properly attended to, if the patient will refrain from stimulants and live on good food, taking moderate exercise, etc. I cannot speak of the value attached to puncturing the dura mater, never having seen it practised.

Hypertrophy of the Stomach with Pyloric Stenosis.—**Dr. W. Watt Kerr** said: I had hoped to present to the Academy to-night a pathological specimen of a stomach. The history in brief is as follows: A man, 52 or 53 years of age, had suffered with persistent vomiting of long standing, and was quite emaciated. The vomiting was finally controlled and patient kept on milk diet. After a short time he was given a test breakfast, and free hydrochloric acid was found in the contents of the stomach. On physical examination, no tenderness or tumor could be found over the epigastric region. The patient was kept on milk diet. There was persistent constipation and the bowels were moved by high enemata; for four or five days small pieces of fecal matter were passed. A little later the patient died. At the autopsy it was expected that a tumor of the pylorus would be found and a dilated stomach, but instead we found a very small stomach with walls all of half an inch in thickness. The pylorus had contracted so that a lead pencil could not pass through. The cardiac orifice was normal.

Dr. D. W. Montgomery: Dr. Stallard had a case a few years ago with similar symptoms. It afterwards passed into the care of Dr. Taylor, and some time after died The stomach was found to be quite small, with walls an inch thick, the pylorus also being very narrow. A microscopical section showed the peptic glands atrophied, and the walls of the stomach contained a great deal of fibrous connective tissue.

Dr. W. S. Thorne: The constriction of the pylorus and hypertrophy of the walls is really a condition of hypertrophic dilatation; the dilatation is prevented by the hypertrophy of the muscular walls.

Dr. G. F. Shiels: Might not Dr. Kerr's case have been a diffuse deposition of epithelial cells? Was the pylorus only affected?

Dr. Kerr: In this case, after a test breakfast, and the phloroglucin test, there was a fair amount of hydrochloric acid demonstrated; this would show that the stomach was in fair condition. I had the same theory as Dr. Thorne. The whole stomach was hypertrophied, the hypertrophy extending from the walls into the pylorus.

Dr. L. B. S. Pawlicki had had a very similar case, which, however, was complicated with cancer of the breast. On *post-mortem* examination, both kidneys were also found degenerated.

DR. THORNE: Speaking of persistent vomiting, a case of this character was recently admitted to St. Mary's Hospital. Patient was a German woman and pregnant, and suffered with persistent vomiting. Everything failed to relieve it. The urine was repeatedly examined and found perfectly normal. It was suggested to paint the cervix uteri with carbolic acid and tincture of iodine. This was done, and the vomiting was arrested for 36 hours, when it returned. Internal medication failing, the carbolic acid and iodine were again applied to the cervix, with the result of stopping the vomiting for two days. Finally it became alarming and we induced premature labor. In 24 hours the house surgeon delivered her of an excessively fetid fetus; jaundice then set in. The point in that case is that the vomiting was not reflex but septic, yet it was controlled by the applications to the cervix.

DR. MONTGOMERY: Dr. Hund had a case of persistent vomiting that collapsed and died. On *post-mortem* examination there was nothing in the gross pathology, but microscopically there was a cloudy swelling of the epithelium of the kidneys.

DR. L. ROBINSON: In Dr. Thorne's case, the fetus was nearly absorbed, only a few bones were left; the woman was in this condition for four months.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, January 8, 1894.

The President, ALBERT ABRAMS, M.D., in the Chair.

New Members.—J. S. BARRETT, M.D.; G. W. BURK, M.D.; M. S. COFFMAN, M.D.; F. X. EMERSON, M.D.; H. S. GOSSAGE, M.D.; C. C. HANSEN, M.D.; L. C. HULL, M.D.; J. A. MCNEAR, JR., M.D.; HENRY MEYER, M.D.; H. O. MILLER, M.D.; ALEXANDER PATTERSON, M.D.; W. F. SOUTHARD, M.D.; FRANK P. WILSON, M.D., were duly elected members of the Society.

DR. CLINTON CUSHING read a paper entitled "Abdominal Surgery in Northern Germany." [Published at p. 113.]

DR. A. BARKAN reported a case of "Fatal Secondary Hemorrhage following Removal of Pharyngeal and Faucial Tonsils." [Published at p. 118.]

DR. R. H. PLUMMER described the normal blood supply to the tonsil and the more common anomalies in distribution and size of the arteries, illustrating his remarks with a large drawing.

DR. L. C. LANE: The paper just read is so complete in its details that it hardly admits of much addition from me. The doctor is greatly to be praised for appearing before us and telling us of one of his unfortunate cases. If it were customary to do this our statistics would be of greater value. To stand up before a medical society and detail the history of such a case, with its attendant pain, requires a great deal of moral courage. It has been said that if some one would write a book of the unfortunate cases it would be the greatest book in surgery. I have done this operation a number of times, but it has not been my misfortune to have a fatal case. I remember a case in the practice of an eminent surgeon in this city which bled for 12 hours and died. The hemorrhage was explained by anomalous position or size of the arteries. In my experience I have had much to do with severe hemorrhage. In one case, in which I had Dr. Toland in consultation, I amputated a leg, and finally lost the patient from secondary hemorrhage. This is the experience of every man who has done much work of this kind. The fact that Dr. Barkan has performed the operation of tonsillotomy 800 times without accident, is the best proof that can be given that the operation was well done; and I am sure that no one will be able to do 800 such operations again without a fatal case. In Henle's famous book there are some curious things. A case is reported where the carotid is absent, but is replaced by branches of the internal maxillary artery passing close to the tonsil. From the history of this case it is evident none of the larger vessels of the neck were opened. I had the misfortune once to do this. There was no time to send for a doctor. Prompt ligation of the carotid prevented what would otherwise have been a fatal hemorrhage. I remember several cases of great hemorrhage from the mouth. An Italian child had a tooth pulled, and bled incessantly. We resorted to pressure, to tamponning; I even tied the common carotid, but it was of no use. This condition of hemophilia may be due to lack of fibrin in the blood, or to lack of development of the circular fibres of the vessels. I am inclined to think that the former is more in accord with the facts.

Dr. S. Trask: Removal of the faucial tonsil is as old as medicine, but the removal of the pharyngeal tonsil is modern. The causes of death from the operation are hemophilia, or anomalous distribution, or size of the arteries. This case is unique.

Dr. W. F. Southard said he had not had a fatal case of tonsillotomy, but probably this was because he had had fewer cases—about 200—but he never operated without misgivings. We can sometimes, by the history, exclude bleeders. He has refused to operate on some cases. If one fears to use the tonsillotome he may use the cautery, but the tonsillotome is to be preferred. He had one case of fatal hemorrhage from the posterior nares, the patient dying after two or three weeks of frequent bleeding. An ordinarily insignificant operation was performed on the anterior portion of the nostril followed in a couple of weeks by hemorrhage from the posterior nares, which, however, was easily checked. A surgeon was called in consultation, but it was thought that no operation was required. Subsequently it was learned that the patient was a bleeder.

Dr. Stanley Stillman: It seems to me that the lesson to be learned from the paper is that there is such a thing as secondary hemorrhage from the tonsil. The text-books give minute descriptions of what should be done during the operation to avoid hemorrhage, and after it to check the resulting bleeding—hemorrhage primary; but they are silent on the matter of hemorrhage occurring after the patient has left the office and gone home—secondary hemorrhage.

Dr. C. E. Farnum had seen two cases in the dissecting room in which the internal carotid curved forward passing directly external to the tonsil. Treves puts the internal carotid four-fifths of an inch posterior to the tonsil.

Dr. H. M. Fiske mentioned a tonsillotomy by David Brainard, which he witnessed in Rush Medical College. Sudden and profuse hemorrhage followed, and the child was carried from the operating room dead.

Dr. C. E. Farnum reported a case of "Anomalous Position of the Cecum and Vermiform Appendix, and of the Sigmoid Flexure of the Colon and Rectum," found in the dissecting room [published at p. 124].

Dr. L. C. Lane said that in line with this observation he would report a case that had come to him with the story of having been treated for an abdominal aneurism for several months. The signs of aneurism were not altogether satisfactory, so the abdomen was opened, and in the median line the transverse colon was found prolapsed downward, so that the lower portion lay over the bifurcation of the aorta. The colon becoming periodically filled with fecal matter and pressing on the aorta accounted for the pulsating tumor. The colon was found filled with feces. The aorta was as sound as it could be. The patient recovered from the operation, and says he is much improved. The reason for his improvement, as has been observed after many surgical operations, cannot be explained by what was done for him.

SPECIAL CORRESPONDENCE.

VIENNA

The Number of American Students at the Vienna Clinics.—Medical Women, the Increased Privileges afforded Them.—Poor Accommodations for Students.—The Quarters of the Vienna Medical Society.—Prof. Billroth's Health.—Accident to Dr. Monti.—The Vienna Polyclinic.

In looking over the Register of the Vienna University for 1893–94, it is noticeable that a larger number of the students than ever before, are *auserordentlische*—that is, not registered for a degree. The total number of students is 5,431, of which number 3,962 are regularly inscribed, and 1,469 are going independently to the lectures. Sixty-three Americans belong to the latter number, and but one American is enrolled for a degree. Looking over the various nationalities in attendance on the medical clinics, we find that outside of Austria, America leads in numbers. Sixty-four Americans, fifty-eight Prussians, forty-six Russians, twenty-one Englishmen, fifteen Bavarians, eleven Swedes, five Japanese, etc.

Among the Americans, a larger number of female students is noticeable, and their names in the Register is not the only indication of their presence. On my previous visits to the clinics of Vienna, I had often wondered at the courage of our country women in coming into a medical circle whose ideas of woman's subjugation were so strong as in Austria. In those years the obstacles were great. Professors and students, with few exceptions, made the life of a female medical student a hard one. They did not encourage their attendance. But on this visit I notice a pronounced change. Lady students are admitted to all the courses, treated like ladies, and in the obstetrical clinic of Professor Shauta—the successor of Carl Braun von Fernwald—special seats in the front row were lately given to two American lady students. Of course, it is useless for a lady to try for a degree in Austrian medicine, but the sex may well be satisfied with the increased privileges allowed them, over as recent a date as 1888.

The accommodations of the students, such as amphitheaters, reading rooms, wash rooms, etc., has never occupied the attention of the faculty at Vienna. The same style of seats, same seating capacity, same style of amphitheaters, that suited in the time of Joseph II, is still in use. In my recollection, a new clinic, the third medical, has been erected with an amphitheater of more modern pretensions. But the remaining twenty-five hundred students still sit on circus seats, breathe foul air, and hit their heads on dirty ceilings or trip headlong down the steep and narrow, poorly lighted stairways.

Quite the reverse are the new quarters of the Vienna Medical Society. This society, one of the oldest in existence, has erected a building devoted exclusively to its purposes, and a model of its kind. Billroth, the well known surgeon of Vienna, was President of the society, and opened its doors to the profession in October, 1893. It is a three-story building of large area. The first floor is devoted to a well-lighted and well-stocked library; a good sized room also is devoted to current periodicals, and several smaller rooms on the same floor do service as smoking and lounging rooms. The main entrance hall is spacious and the walls are decorated in the modern Rococco style. The upper floor, embracing two stories, contains the hall for medical meetings, and two smaller audience or committee rooms. It is the arrangement of this assembly hall which is so interesting. Around its entire border is a gallery about two feet in width and closed in beneath. This space is used as hallway (doors open into each aisle of the auditorium) and the side next to the street has special stands for microscopic work. The auditorium itself is arranged with raised platform for the chair of the President, and, slightly lowered, a second platform, for the exhibition of patients. The 250 seats are arranged in theatrical style and sloping toward the platform. The space behind the President, and inclosed beneath the gallery, is fitted up as dressing and preparatory rooms for patients, with hot and cold water, electric light, good toilet arrangements, and comfortable seats. None but members are allowed on the floor during a session. The visitors find good seats in the gallery. The usual attendance is about one hundred members. The cost of membership is about $4.00 a year, and meetings are held every Friday night.

Billroth has long suffered from a bronchial catarrh which, in the past few weeks, has compelled him to give up his lectures on surgery—only temporarily, it is hoped.[1] His first assistant lectures in his stead to empty benches.

Dr. Alois Monti, Director of the Vienna Polyclinic and Professor of Diseases of Children, fell, lately, through a cellar-hole in the Polyclinic, and suffered a bad fracture of the right ankle. This Polyclinic, one of the noble institutions of Vienna, is rather a vent for the over-pressure in the vast general hospital. It occupies new quarters in the neighborhood. Winternitz, so well known in connection with the water-cure system, has built, at his own expense, a separate division of the Polyclinic and fitted it with his apparatus. The bathing department is so arranged that students from an elevated platform in the middle of the bath house can see the patients in the various baths and note the methods used by the attendants. The sights there remind one of a visit to the Syphilis Clinic of Prof. Neuman, where a stitch of clothing on a patient before the class, is an unheard of sight. G. C. SIMMONS, M.D.

VIENNA, January 21, 1894.

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[1] Billroth died Tuesday, February 6, 1894, expiring in an asthmatic paroxysm.

PARIS.

[FROM OUR OWN CORRESPONDENT.]

Philanthropy and Medical Science.—Diminution in Infant Mortality by the Couveuse.—Madame Henri's Couveuse Department at the Paris Maternity.—Subsequent Care of the Children.—An Acute Stage of Hospital Reform.

Philanthropy and medical science are closely allied; Mme. Henri, the accomplished *sage femme en chef* of the Maternity Hospital, has given a practical proof of this by founding and organizing a *couveuse* department at the Paris Maternity Hospital. All the qualities necessary for the success of this enterprise, power of organization, foresight, a scientific knowledge of hygiene in all its applications, ventilating and disinfecting buildings, with the medical treatment of infant life, joined to a powerful, well directed will and a warm, generous heart. The outcome of all these qualities make an epoch in the medical treatment of infant life.

The depopulation cry which has quite scared the gray-headed members of the Paris Academy of Medicine, and occupied so many of their meetings, lends an additional interest to Mme. Henri's medical and philanthropic enterprise. Before her *couveuse* department was in full working order, only, as Mme. Henri expresses it, "doing what she could," infant mortality was greatly reduced. Now, that a greater number of children can be admitted and treated, with the united care and utmost medical skill, as our description of the *couveuse* department will show, it may be foreseen that infant mortality among the new-born will be reduced to a very much smaller figure. In the early days of the *couveuse* the mortality was reduced to 33 per cent. Mme. Henri's improvements have reduced it to 63. It is to be hoped that this encouraging present and promising future will bring comfort to the gray-haired academicians, and furthermore suggest to them and others to go and do likewise. Special pleading is not necessary to establish the fact that if the greater part of the babies prematurely born grow up to be strong men and women instead of dying in babyhood or childhood, the population is increased by so many lives, which in their turn will furnish more; thus Mme. Henri's medical philanthropy appeals not only to scientists and philanthropists, but also to social economists.

The *couveuse* department of the Maternity, which was inaugurated a few weeks ago, consists of several wards specially arranged—all gay and pretty. The general ward is 30 meters long, and is warmed by a thermosyphon, the pipes springing from it are carried round the room; this system is similar to that of hot-houses; in fact, these prematurely born babies *are* reared in a hot-house; the walls are painted, a necessary hygienic precaution, but estheticism does not suffer. Mme. Henri has carefully chosen a subdued rose tint; the floor composed of many-colored flagstones is also picturesque and hygienic. The furniture is exclusively of iron, thus all antiseptic measures are easily carried out. On one side of the room there are 14 cradles arranged in a row, on the other side 14 *couveuses*. It is perhaps time now to minutely describe a *couveuse*, which is, in reality, a large oblong glass case, with an upper and lower compartment. This case is mounted on four feet, with castors; in the upper compartment there is a soft, clean little mattress; on this the baby is placed. In the lower compartment is the receptacle containing boiling water; this, by a simple arrangement, is emptied and refilled without being removed. The important detail is to maintain in the *couveuse* an unvarying temperature of 30° C. In order to insure this the water must reach 80° C. The babes can thus live several weeks within a glass case. The health of the patients is ascertained by weighing them; the result is tabulated and placed at the head of their *couveuse*. In order to prevent exchanges each child wears a necklace with a locket, on which is inscribed its name, and the date of its appearance at the hospital. The babes are washed and dressed in a special room, called the *crèche*, where the temperature is higher than that of the general room; the arrangements for washing are perfect. The children are suckled or brought up by hand, according to their condition; some are given the breast and the bottle; the milk used for the bottles is carefully sterilized. The wet nurses occupy at night a large dormitory, and by the side of each bed is a cradle for the accommodation of their own child; the inmates of the *couveuses* are in another part of the building. The isolating wards, where babes with contagious affections are placed, resemble big glass cells, in which is the *couveuse*, or cradle, according to the age and condition of the little sufferer. Mme. Henri intends adding to this babe-rearing establishment a carriage drawn by goats, also a donkey, in order that the babes which are strong enough and old enough can be taken out for an airing, and thus accustom them gradually to the out-door temperature before sending them to their own homes.

The "Union Française pour le sauvetagè de l'enfance" and Bequet's "Attachément Maternel" supplement, in a measure, Mme. Henri's enterprise. Mme. Bequet aids poor mothers to bring up their children, and by insuring their hygienic condition combats the invasion of pathological conditions. The "Sauvetagè de l'enfance" seeks out and rears, honestly and healthily, all children who are ill used or deserted by their natural protectors, also the friendless and homeless, thus arresting the march of disease and crime among the infant population. The reports of these societies are too bulky to sum up here, but the results of both enterprises are in the highest degree satisfactory, and encouraging as examples of what philanthropy can and ought to do to arrest the invasion of pathological degeneration, which, in the majority of cases, leads to crime.

Hospital reform has reached, in Paris, not only an acute stage but a diffused one. It is asked for everywhere, from the top of the ladder to the bottom. Reform among the staff, reform in the rules and regulations, concerning visiting days, admission of patients, also in the wards, in the gratuitous treatment of outdoor patients, reform in the commissariat department, less waste and better prepared food is demanded. It is asserted by some well informed authorities, that a certain number, or perhaps, more correctly speaking, an uncertain number, of hospital *chefs* greatly prize the honor and power attached to their position, but treat lightly their duties; finding it more lucrative to sit on a great many commissions, sittings resulting in a fee, or to pass their winter in peace and sunshine far away from the sphere of their duties, where soft winds and the scent of orange-flower blooms replace the sight and sounds of human suffering. The "Conseil de Surveillance" of the "Assistance Publique," has been revised, some members of the medical staff attached to hospitals are placed on it, and there is a question of reviving a law which obliges a reëlection of hospital physicians and surgeons every five years. There is much to be said for and against this proposition. Every opportunity which favors and calls into action intrigue, is best avoided; elections do this to a lamentable and immoral degree. It is quite possible that reëlection might serve to eliminate the best men. It is a general rule here that real medical and scientific worth is in inverse proportion, *not direct*, to the faculty of intriguing. If such men as Potain and Tarnier were not so scarce the cry for reform would not be heard, but now it is wise and perhaps urgent. Let us hope that the result we shall have to chronicle will be satisfactory.

PARIS, February 5, 1894.

OBITUARY.

CHARLES EDWARD BLAKE, M.D.

DR. C. E. BLAKE was born in Holden, Maine, August 14, 1845. He was a descendent of an old New England family on his father's side, and through his mother of the family of John Rogers. His first arrival in California was in 1851. His father, Charles Morris Blake, established and conducted what was afterwards St. Augustine's College, at Benicia. After three years, the family removed to Chili. From here he was sent to Yale College, where he graduated in 1865, in his 20th year. He began his medical studies in the Medical College of the Pacific, in 1870, at which school he graduated in the class of '73, being one of twelve, six of whom, until his decease, were practitioners in San Francisco. He divided the honors and prize with Jos. O. Hirschfelder, in the junior year. Dr. Blake did not aspire to a position as a leader in the profession; yet, as a practitioner, he occupied a prominent place and enjoyed the reputation of being a thorough and able man. He was prominent in the medical societies; was often chairman of a committee in the State Society. He was a member of the Board of Examiners for several years, serving for a time as secretary, doing the work of editing the Medical Register, producing the best volume in its history. His illness dated back about thirteen months, a violent attack o diphtheria, contracted from a patient, resulting in a heart lesion which, unfortunately, was not discovered until he was far away from home and friends, in search of health. He went to the Sandwich Islands, believing he needed rest, where Dr. Trousseau, of Honolulu, discovered the heart trouble. He returned, depressed in spirits and broken in health; yet he resumed his professional duties, and literally "died in the harness," expiring in the house of a patient, where he had gone to make a professional visit. The immediate cause of death was the detachment of a valvular vegetation, which reached the brain. His death was not altogether unexpected by his family and intimate friends. He was fully impressed with the impending danger of his position, yet he went about, attending to his duties, calmly awaiting the crisis, always accompanied, however, by his faithful wife, or other members of his family. But few men could exhibit such indomitable courage and display even a cheerful countenance to those about them. Dr. Blake was a man of most exemplary character, an earnest student, an able physician, a worthy and useful citizen. No higher tribute could be paid to a man than this: That, during student and professional life, he has left no act or word, in memory of contemporaries, either unkind or unjust. C. G. K.

The Children's Hospital, San Francisco, In Memoriam of Dr. C. E. Blake.

The undersigned, members of the medical staff of the Children's Hospital, were appointed to take due notice of the death of the late Dr. Charles E. Blake. The staff feel deeply the great loss his death has caused to the Children's Hospital, as well as to the medical profession of California. He was a worthy example of a self-made man. It has been well said that he was a manly man. He was essentially a modest, conscientious, and christian physician, always avoiding effort to win or attract public notice. Though he had lost little time from active work, it was known about thirteen months ago that his health had failed, never to be entirely restored. His sudden end was a sad surprise to relatives and friends. He had many friends, both in and out of the profession. He was too young to die, yet he had accomplished much, and his example will remain as a lesson, we hope, to many of our profession. He was faithful to a great trust. We deplore our loss, and offer to his family our sincere condolence.

A. P. Woodward.
L. M. F. Wanzer.

REVIEWS AND NOTICES.

Syllabus of Lectures on the Practice of Surgery, arranged in conformity with the American Text-book of Surgery. By N. Senn, M.D., Ph.D., LL.D., Professor of the Practice of Surgery and Clinical Surgery in Rush Medical College, Professor of Surgery in the Chicago Polyclinic, Attending Surgeon to Presbyterian Hospital, etc. Philadelphia: W. B. Saunders.

In the preface the author has clearly stated his motive for the issuance of this unique textbook. The work was prepared to meet the requirements, first, of teachers of surgery, as an aid to systematic work in the lecture room; and secondly, of students, for the purpose of enabling them to differentiate the essentials of matter presented in a course of lectures or study. It is but fair to add that the practitioner will find in this volume a most useful ally, as he approaches work with which he is not altogether familiar. The general plan of the work is sufficiently indicated by the title: it is a "syllabus," pure and simple. For care and thoroughness in preparation, Professor Senn's name is a sufficient guarantee. In no respect should it be classed with the Surgical Handbook. It is presented as a guide, or key, to subsequent research, and not as an aid to memory, for use during examination week. This book should lie upon the desk of every surgeon.

A Clinical Text-book of Medical Diagnosis for Physicians and Students, based on the most Recent Methods of Examination. By Oswaldt Vierodt, M.D., Professor of Medicine at the University of Heidelberg, etc. Authorized translation, with additions by Francis H. Stuart, A.M., M.D. Third revised edition, with one hundred and seventy-eight illustrations, many in colors. Philadelphia: W. B. Saunders, pp. 700. Price, cloth, $4.00.

This work, a recent edition of which has been favorably reviewed in these columns, has met with such a reception from the profession that the demand has been supplied by the edition before us. It has been most carefully revised and in every way the high standard of former issues has been maintained. Perhaps the best evidence of the intrinsic value of this book is the fact that it has already been translated into nine foreign languages. While, as the title implies, the newest methods in diagnosis have been given, the reader cannot fail at being impressed with the great weight that the author lays on the importance of clinical diagnosis. It is too much the custom at the present day to ignore this factor in the investigation of morbid conditions, and to rely mainly on the laboratory instead of regarding the latter as supplemental of those methods of investigation that are within the reach of all, and by which in many cases a diagnosis of the most accurate description is possible. This practical element is certainly the most valuable feature of a work which stands to-day as the very best of its class.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held February 6, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

Gerald R. Burney, San Francisco; Rush Med. Coll., Ill., March 25, '90.
George W. Corey, Sacramento; Rush Med. Coll., Ill., Feb. 16, '59.
Abraham L. Cothran, San Francisco; Med. Dept. Univ. California, Dec. 14, '93.
Thomas Jefferson Edgecomb, San Francisco; Rush Med. Coll., Ill., March 25, '90.
Edward F. Geoghegan, San Francisco; Royal Coll. Surg., Dublin, Ireland, May 4, '80; King's and Queen's Coll. Phys., Dublin, Ireland, Dec. 10, '80.
H. S. Gossage, San Francisco; Cooper Med. Coll. Cal., Dec. 7, '93.
Graily Hewitt Hall, San Jose; Cooper Med. Coll. Cal., Dec. 7, '93.
Ellis Harbert, Waterford; Med. Dept. Vanderbilt Univ., Tenn., March 1, '93.
Henry R. Heydecker, Coronado; Harvard Univ. Med. School, Massachusetts, June 26, '89.
Edward F. Holbrook, Smartsville; Cooper Med. Coll., Cal., Dec. 7, '93.
Leonard Charles Hull, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
Edward G. McConnell, San Francisco; Cooper Med. Coll., Cal., Dec. 7, '93.
John McIntyre Morrison, Berkeley; Cooper Med. Coll., Cal., Dec. 7, '93.
Clarence W. Rairdon, Santa Ana; Univ. Kansas City, Mo., March 14, '89.
Edward B. Robinson, San Francisco; Queen's Univ., Kingston, Ontario, Canada, April 8, '91.
Alfred S. A. Sander, Alameda; Univ. Berlin, Germany, Aug. 11, '93.
Wm. Parsons Sawyer, Grass Valley; Med. Dept. Univ. Pennsylvania, May 1, '91.
John Edward Shaw, San Jose; Univ. Toronto, Canada, June 8, '80; Royal Coll. Phys. and Surg., Edinburgh, Scotland ,Oct. 29 '80; Trinity Univ., Toronto, Canada, May 11, '81.
Eustace Trenor, Alameda; Coll. Phys and Surg., N. Y., Oct. 13, '56.
Edward Albert Vogt, Palmdale; Missouri Med Coll., Missouri, March 11, '74.
Maude A. Waterhouse, Haywards; Cooper Med. Coll., Cal., Dec. 7, '93.

The following were refused certificates, as the credentials presented were not satisfactory:

John Daniel Caldwell, Manton; S. Takegama, Sacramento.

CHAS. C. WADSWORTH, Secretary,

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from Jan. 20, to Feb. 20, 1894.

The journeys performed by Captain R. R. Ball, assistant surgeon, from Fort Townsend to Seattle, Wash., and return, on January 2d and 30th, 1894, on public business in connection with the examination of recruits, in obedience to instructions from these headquarters dated April 5, 1892, are confirmed. Par. 1, S. O. 19 Dept. of Columbia, February 3, 1894.

First Lieutenant Euclid B. Frick, assistant surgeon, is relieved from duty at Fort Keogh, Mont., and ordered to Fort Townsend, Wash., for duty at that post, relieving Captain Robert R. Ball, assistant surgeon. Captain Ball, on being relieved by Lieutenant Frick, will report in person to the commanding officer at Fort Monroe, Va., for temporary duty.

Colonel Joseph R. Smith, Assistant Surgeon General U. S. Army, is detailed to represent the Medical Deparment of the Army at the Eleventh International Medical Congress, to be held at Rome, Italy, March 29 to April 5, 1894, and will proceed to the place designated at the proper time.

Leave of absence for one month and ten days, to take effect upon the adjournment, of the Eleventh International Medical Congress to be held at Rome, Italy, March 29 to April 5, 1894, is granted Colonel Joseph R. Smith, Assistant Surgeon General.

ITEMS.

Dr. A. A. De Puy has removed from Smith River, Cal., to Crescent City, Cal.

Dr. P. J. H. Farrell, of San Francisco, has removed his office to 235 Post street, cor. Stockton, rooms 4, 5, 6 and 7.

Occidental Medical Times.

Vol. VIII. APRIL, 1894. No. 4.

AN ADDRESS.

Delivered at the Semi-Annual Meeting of the California Northern District Medical Society.

By Wallace A. Briggs, M.D., President, Sacramento, Cal.

How Medical Societies May Best Promote the Welfare of the Medical Profession and of the General Public.

Amidst the diversity and apparent clashing of human interests, the medical profession was among the foremost in recognizing their true solidarity. A people, and, on a grander scale, all mankind, constitute a sociological unit, just as the individual man himself constitutes a physiological unit. In national life the social functions are developed and coördinated, just as the vital functions are developed and coördinated in the individual life; and just as vital functions subserve the common good of that organized aggregate of functions which we call man, so, in his various callings, should man himself subserve the common good of that organized aggregate of individual men which we call the state.

With this view, no calling, however lowly or however exalted, has or can have any healthy interests antagonistic to public interests, any normal function incoördinate with other normal functions of the body politic. Unfortunately, this is not the view seemingly entertained by the great mass of mankind organized avowedly for the promotion of vocational interests. Guilds and fraternities and unions without number have been established, mostly with a laudable fundamental purpose, and yet with the tacit, if not the open, declaration that class interests must be fostered at all hazards, regardless of the rights and interests of the people at large. But we need not go to guilds and unions to obtain this illustration, for local, state, and national politics fully exemplify the workings of this pernicious, and, without exaggeration, I may say, this fatal policy; a spectacle that should fill the heart of every patriot with shame and apprehension.

As medical men have been foremost in recognizing this principle of the harmony, the solidarity, of healthy human interests, so medical societies should be foremost in its practical realization. The physician is also a citizen, and that specialization of function which fits him for his vocation fits him also for certain important and special functions of citizenship, to which I now invite your attention.

In the active promotion of sanitation and prophylaxis, medical societies should maintain the honorable record they have already established. It is here that medical men were among the foremost in recognizing the real solidarity of human interests, and it is here that the great triumphs of the future await them.

Science is constantly enlarging the already formidable list of infectious diseases, and we can no more afford to be remiss in the prevention of tuberculosis than in that of small-pox or of cholera. I invoke your attention to these subjects, and particularly to quarantine, and other means of preventing the spread of tuberculosis by man, as well as by the lower animals.

Medical societies may do a great service to mankind by using their influence in preventing criminal abortion. Infanticide is openly abetted by several of the self-styled "great dailies"—great only in their bulk and nefarious influence. In their columns, under the heading "Medical," may be found a dozen undisguised advertisements of professional abortionists. Evidently such journals have just as perverted notions of morality as of medicine.

Infanticide is practised quite as extensively, and almost as openly, as it is advertised, and not by any means exclusively by professional abortionists; "doctors," midwives, nurses, women themselves engage in it. It is *the national crime.*

The decline of maternity, of which criminal abortion is a really appalling aspect, has been taken up by Dr. Powell, and I trust that his paper will elicit the discussion which it will surely deserve.

The evils of quackery in its various forms have attained enormous proportions. Tippling has been termed the national vice; infanticide is the national crime; and patent medicines may be called the national superstition.

Medical societies may assuredly do something to diminish these evils: in the first place, by promoting the diffusion of that knowledge which is really of most worth, the only means of true and permanent progress; secondly, by enforcing the State medical law in its application to quacks and quackery; and lastly, by securing the enactment of a law prescribing that the formulæ of all patent medicines and nostrums shall be printed and attached to every bottle or package.

Medical societies may promote the common interests of the medical profession and of the public by refusing professional association with irregular physicians, of whatever creed. In illustration of my views on this subject, I can do no better than quote from a leading article in the OCCIDENTAL MEDICAL TIMES, of June, 1893:

"In the first place, scientific medicine, like every other natural science and equally with every other natural science, is based on observation, experiment and induction. This, it insists, equally with other sciences, but no more than other sciences, is the only method of reaching the truth. Without this method, it insists that no man can be a scientific physician; or, in other words, in any worthy sense, a physician at all. But while it insists on the methods of science, it is tolerant of the widest divergence of opinion and practice. It has not assumed and does not prescribe any general law of therapeutics, to which all facts must either conform or be relegated to the limbo of apocrypha. It is, therefore, broad enough for every scientific physician, of whatever belief or shade of belief.

"The scientific physician insists on the methods and accepts the results of scientific investigation. With those who pursue different methods and accept different results, he has no common ground. He cannot abandon his own methods, for he knows them to be approved by science in all its departments; he knows them to be the methods on which all progress is based. Those who pursue different methods are not likely to give them up; and if they should, they are in no condition either to receive or to offer scientific opinion. Consultation, therefore, in the true sense of the word, is impossible between the scientific and the sectarian physician. By restricting professional association scientific physicians can influence and control medical education, and elevate the standard of capacity and attainment among medical men. Instead of being extended to irregular physicians, recognition should be restricted—even in the regular profession.

"The resolution adopted by the State Medical Society instructs its Board of Examiners to refuse licenses on diplomas emanating, after the year 1894, from schools that do not require a thorough preliminary education, and a full four years' course in medicine proper, is in the right direction. Enforced by the various State and local medical societies, such a resolution would do more than anything else to elevate the medical profession to the plane it should occupy. If recognition should be restricted to the *competent* within the *regular profession*, why should it be extended to the *incompetent outside?*"

Medical libraries are essential to medical progress, and therefore contribute materially to the welfare both of the medical profession and of the public. That vast repository of medical knowledge—the Library of the Surgeon-General—has imparted an appreciable impetus to medicine in America. A really efficient reference library is beyond the means of individual physicians, and were it not, private libraries are in constant danger of dispersion by death and adversity. Such a library, therefore, should be under the charge of some permanent body of abundant means.

The Medical Department of the California State Library has had a nominal existence for a number of years, but to save it from a pernicious anemia it needs the infusion of considerable new blood. It would form a valuable nucleus, however, for such a library as we need on the Pacific coast. Steps have already been taken to urge upon the Trustees the importance of making the library a creditable repository of the literature of our profession. The coöperation of this Society, and of other medical societies, would be of material assistance in this work. Let it no longer be possible to say that as far as the medical library is concerned the Capitol is a splendid mausoleum where lies interred the literature of antiquity.

The investigation of climatic influences in the development, progress, and *especially* in the relief and cure of disease, may profitably engage the attention of the California Northern District Medical Society.

The climate of Northern California is diversified in the extreme. The great Sacramento—San Joaquin valley, but a few feet above sea level, varying in different sections in rainfall, in atmospheric humidity, in diurnal variations of temperature, and in other minor climatic features; the foothills and the higher altitudes of the Sierra, in their multitudinous variety of elevation, exposure, and surroundings; the numberless valleys, the undulating foothills of varying altitude, and the higher plateaus, and the mountains of the Siskiyou Range, and of the Coast Range on its inner and its outer slope; and finally, the coast itself with its inlets, curves, and indentations, variously exposed or protected, afford a field of study as promising as it is varied and extensive.

Dr. R. F. Rooney has taken the initiative in this work, which I hope will be continued by himself and other members of this Society, until science is enriched by a thorough knowledge of the climatic resources of Northern California.

Education is a physiological process that should be conducted under hygienic conditions. The physician, therefore, should be peculiarly fitted to judge of educational matters, and the more so because his wide observation of human nature, and of the conditions of success in life, should enable him to form an intelligent opinion as to what knowledge is of most worth.

The failure of education, of which so much has been said of late, and of which the physician is the constant, but too often the silent witness, is due chiefly to three causes: The pursuit of knowledge of inferior worth by unphysiological methods under unhygienic conditions.

The physician knows better than most men that in our public schools the true proportions of education are sacrificed to ignorance, to prejudice, to expediency, to superstition. The highest praise ever bestowed on these schools is that they fit their pupils not for life, that great and exacting university which all of us must enter prepared or unprepared, but for succeeding schools, and finally for the University of the State of California. Small praise indeed, when we remember that not one in ten of the grammar school pupils reaches the high school, and not one in ten of the high school students reaches the State University.

The failure of education I have said is due chiefly to three causes: The pursuit of knowledge of inferior worth by unphysiological methods under unhygienic conditions. But back of all this, and really fundamental, is the withdrawal of our public schools from the struggle for existence, and of our public school teachers from the operation of that salutary law—the survival of the fittest. Not that teacher who is most desirous and most capable of inspiring enthusiasm for virtue and for knowledge, but he who is most skilful in the use of those influences which prevail in American politics is sure of selection and promotion in our public schools. The fittest survive indeed! The fittest not educationally, however, but the fittest "politically."

Exceptions, many exceptions, to this rule exist, it is true, but they serve only to bring the rule into a more glaring light, to indicate what our public schools might be were they controlled by business rather than by "political" principles.

But the question of education concerns the medical profession yet more nearly. The responsibilities assumed by the physician are of the most difficult and the most sacred. Every consideration of duty and of interest impels us to see that these responsibilities are neither lightly assumed nor perfunctorily discharged. Medical societies, therefore, should use their influence in elevating the standard of medical education. By so doing they will contribute to the prevention of over-crowding of a profession already replete; securing to medical men their rightful place in public esteem; securing to respectable medical schools that moral and pecuniary support to which they are entitled, and more than all else qualifying the physician for the arduous duties of his calling.

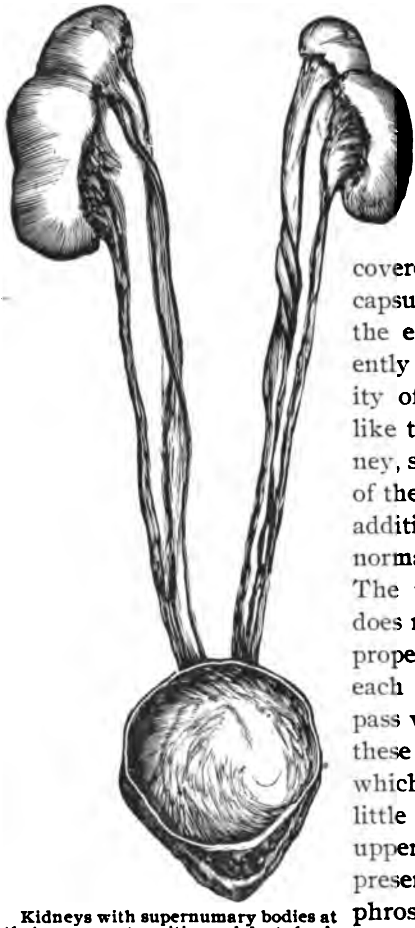
SUPERNUMERARY KIDNEYS WITH PERSISTENCE OF THE MUELLERIAN DUCTS.

By Robert L. Jump, M.D., Assistant Demonstrator of Anatomy, Cooper Medical College, San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

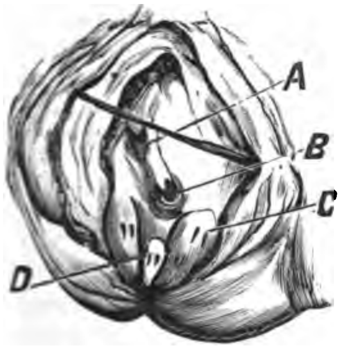
The individual possessing this peculiar addition to his genito-urinary apparatus, was a male, aged 47. The kidneys were situated apparently in their normal position, behind the peritoneum. The anatomical abnormalities present are symmetrical, the pathological process is more advanced in the left renal bodies. The anomalous condition consists in the addition of a supernumerary kidney to the upper extremity of a kidney of about the normal size and shape, and of the passage from each upper kidney of a much dilated, thick-walled ureter to the prostatic portion of the urethra.

Each upper segment is vertically about half the size of the lower, of the same breadth, and of almost the same thickness, covered by a direct continuation of the capsule of the lower organ, and from the exterior their structure is apparently continuous. The upper extremity of the additional body terminates like the extremity of any normal kidney, so that the whole body, consisting of the normal kidney and its abnormal addition, presents the appearance of a normal kidney considerably elongated. The interior of each upper segment does not communicate with the kidney proper below it. The upper body on each side has a hilum through which pass veins, nerves, ureter, and arteries; these arteries are derived from branches which supply the lower segment. But little kidney substance is left in the upper bodies, and the appearance they present is that found in hydro or pyonephrosis.



Kidneys with supernumary bodies at their upper extremities and ducts leading from them.

The lower segment on each side has its hilum, giving passage to nerves, veins, arteries, and its own ureter. The ureters of these segments or kidneys proper are normal in size and follow their usual course and terminate in the bladder at the posterior angles of the trigone. The ducts of the upper segment take the same general course as the ureters proper, passing behind them and terminating in the prostatic portion of the urethra. The opening of the left one is situated in the median line of the floor of the urethra, three-eighths of an inch above the opening of the left ejaculatory duct. The orifice of the right is situated in the floor of the right side of the urethra, three-fourths of an inch above the opening of the right ejaculatory duct, and one-eighth of an inch to the right of the orifice of the left one. These openings are oval in shape, about one-eighth of an inch in diameter, smooth, the epithelium of the ducts being directly continuous with that of the urethra; and a well marked furrow extends diagonally across the floor of the urethra between these orifices.



Prostatic urethra laid open from above.
A—Opening of right accessory duct.
B—Opening of left accessory duct.
C—Openings of prostatic ducts.
D—Openings of ejaculatory ducts.

These ducts, in size and general structure, bear no resemblance to the proper ureters, as their lumen is almost large enough to admit the end of the little finger, and their walls are thick and hard. As a calculus was found in the lower extremity of the right duct, completely filling it, and the same condition had probably been present in the left one, the difference in their structure from that of the other ureters, was due to the obstruction.

Microscopical examination showed that the walls of the upper segment on the right contained glomeruli and tubules sufficiently normal to carry on their function; on the left the glomeruli were reduced to fibrous masses, and the tubules filled with casts. The wall of the abnormal ducts consisted of unstriped muscular tissue similar to that of the normal ureter.

The prostatic vesicle or masculine uterus is not present. The vas deferens, with its vesicula seminalis and ejaculatory duct, is present and normal on each side. No search was made for the suprarenal capsules. The penis and testicles were of average development; they were not examined at the autopsy.

I have found three anomalies somewhat similar to this, but none just like it, in the literature to which I have had access. In the transactions of the London Pathological Society, 1880, is this case: In a man dying of phthisis and tubercular disease of the urinary organs, both kidneys had two separate ureters, which began in distinct pelves and terminated independently of each other in the bladder. All four ureters were pervious. The kidney on each side presented faint indications of having been double; it was larger than normal and consisted of an upper and lower part, which were continuous. On both sides the ureter contributed by the lower portion was uniformly dilated, much ulcerated, and the corresponding part of the gland was so diseased as to present the appearance of a sacculated cyst, nearly devoid of any secreting tissue.

In Sajou's "Annual" is reported the case of a man, aged 45, in whom an autopsy revealed two large ducts extending from the right kidney toward the bladder, one being a dilated ureter. The other, which originated at the upper part of the kidney, proved to be Müller's duct. An abnormal pouch was found in the bladder near the verumontanum, which was normal as to the orifices of the seminal ducts. The left ureter and Müller's duct opened within this pouch, while the right ureter opened outside of it. The fact that Müller's ducts are the origin of the female internal organs of generation, makes their presence in the male, in whom they are reduced to the verumontanum, exceedingly rare. This case is especially interesting through the fact that in almost every case so far reported, functional disorders incident to the abnormal condition had caused death in childhood.

In the specimen under consideration does the anomaly consist of two supernumerary kidneys and their ureters, as in the case first mentioned, or is it an instance, in part at least, of the retention of structures which ordinarily almost wholly disappear in the male? To determine this, the development of the internal genito-urinary organs in the male and female must be considered. At an early stage of fetal life, when the rudiments of the genital organs are first appearing, no characteristic of either sex is present. The first part of the apparatus to make its appearance is the wolffian duct; from the front part of this develops a body containing vascular glomeruli called the pronephros or head-kidney; behind this develops the mid-kidney or wolffian body similar in structure, and from the posterior end of the duct arises the hind-kidney. The duct leading from the posterior body, which becomes the permanent kidney, is the ureter. The duct from the middle segment is the wolffian duct. According to some authorities, the duct of the pronephros is, in mammals, homologous with the duct of Müller. The pronephros quickly disappears; the duct of Müller then opens by its upper extremity into the peritoneal cavity, its lower extremity being fused with its fellow forms, in the female the vagina and uterus, and above the points of fusion, the fallopian tube on each side. The wolffian body in the female is reduced to the parovarium, and its duct is scarcely to be traced on the uterus and vagina.

In the male, the wolffian body forms the vasa efferentia, and its duct forms the tube of the epididymis, the vas deferens, and ejaculatory duct; while the müllerian duct forms the sinus pocularis or prostatic vesicle. This vesicle of the prostate, also termed the masculine uterus, is situated in the substance of the prostate beneath the middle lobe, its opening in the urethra being a little above the center of the verumontanum. On the margins of the orifice are the openings of the ejaculatory ducts. It is lined internally with mucous membrane and has small glands opening on its inner surface. Beyond this prostatic vesicle the müllerian ducts are rarely capable of demonstration in man, even to a slight extent; but in some animals they are continued into horns homologous with those of the uterus.

That the upper segments and the upper part of their ducts are supernumerary kidneys, with their ureters, is evident. That the lower portions of these additional ducts are müllerian ducts, seems possible when their point and manner of entrance into the prostatic urethra is considered, and the fact that there is no prostatic vesicle to be found.

313 Ellis street.

A CASE OF PROCURSIVE EPILEPSY.

By A. W. Hoisholt, M.D., Assistant Physician State Asylum for Insane, Stockton, Cal.

Read before the California Northern District Medical Society.

The term procursive epilepsy (epilepsia procursiva) was first used in describing a certain rare form of epilepsy, by an Irish physician, Arnold Bootius[1], in a work written by him in 1649. Since then a number of medical writers have, from time to time, reported observations of a similar nature, but frequently have confounded the symptoms with those of other neuroses, such as chorea, hysteria and paralysis agitans.

In his work Bootius says: "It has already been observed by several physicians that epileptics do not always fall during a paroxysm, but some have passed through it while standing, others while sitting, and still others while running around in a circle or going about hither and thither. It is worth while to add what we have observed in the case of a boy of 12 years, the son of a schoolmaster living in the town of Drogheda, 24 miles distant from the city of Dublin, on the river Boyne, not far from where it flows into the sea. This boy, as often and whenever epilepsy seized him, ran right forward, not stopping until some obstacle hindered further progress, striking against which, he would fall down."

The complex of symptoms has not until of late years been the subject of much study. The first detailed publication on procursive epilepsy appeared in the *Archives de Neurologie*, in 1887. In it the authors, Bourneville and Bricon, report over 50 cases, in some of which *post-mortem* examinations were made. Upon these observations the writers base their opinion of this form of epilepsy, in which the phenomenon of a sudden running forward in a straight line or in a circle of large radius, having the duration of an ordinary attack, takes the place in part or altogether of the clonic and tonic spasms. The attack is usually not connected with a fall, nor succeeded by coma, but there is a rush of blood to the head.

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[1] Observationes Medicæ de Affectibus Omissis.

The authors have found running epilepsy mostly in young persons, and find it capable of undergoing a transformation into ordinary epilepsy. Four forms of it are met with: Epilepsia procursiva proper (the procursion takes the place of the fit); epilepsy with aura procursiva (the procursion which only is present in the beginning of the disease gradually becomes a forerunner of an ordinary epileptic spasm and finally disappears): epilepsia postprocursiva[1] (the procursion follows an epileptic attack); "vertige procursif" (the procursion is unsteady and associated with other symptoms indicative of vertigo). Its prognosis is unfavorable, and it is frequently complicated by moral insanity. They consider it a symptomatic epilepsy, always caused by a brain lesion, probably a sclerosis of the cerebellum.

Some later writers (Ladame and Mairet, 1889) even say that running epilepsy is accompanied by organic lesion of the brain, and consider the procursion a compulsory or imperative movement, *i. e.*, a coördinated convulsion dependent upon an irritation definitely located in the brain.

In 1891 Dr. Oscar Büttner, of Grossalsleben, Germany, published a paper on "Epilepsia Procursiva and the Significance of the Phenomenon of Running," in which he first gives a resume of the literature on the subject to date, adding two cases that had come under his observation, and afterward criticises the views of the French writers. He considers the procursions "automatisms" like other coördinated movements, and shows that the runinng forward cannot be an imperative movement, nor a coördinated convulsion. An imperative movement, he says, is, in contradistinction to a voluntary movement, the effect of a stimulation, beyond the control of the will and independent of consciousness. An imperative running differs from a simple imperative movement by being coördinated, and coördination is the result of an association of conceptions in the central organ. Coördination of voluntary movements, such as running and speaking, is, however, not predeveloped, but must be learned by experience; they are dependent upon conceptions, which, like the will, are memory-pictures, the after-effects of sense-stimuli, and the brain has hitherto exclusively been considered the organ for the storing away of these. Consequently, coördination of movements, which are not predeveloped as automatic, can only be regulated through consciousness and will power, unless one accepts the existence of secondary centers outside of the cortex for movements learned by experience; and there is no reason to suppose this.

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[1] More correctly, procursio postepileptica.

The cerebellum is generally considered a center for the muscular sense. The individual acts making up the coördinated movements, which are under the influence of the cerebellum, are, during childhood, associated by the cerebral cortex. Later in life, sensations regulating coördination emanate from the cerebellum, rendering a detailed interference with the movements by the cerebrum unnecessary. Experiments on animals have not yielded results corroborating the existence of coördinated, involuntary movements in the human being; we find no examples of instinct-like, imperative running in which, by exclusion of the activity of the will and consciousness, an impulse, from within, to do the act was present.

There is no proof that in man a forward movement of the body can take place by coördinated spasms. The imperative movements described in connection with paralysis agitans, chorea, hysteria, and unilateral brain-lesions are dependent upon the impulses of the will. The characteristic difference between the so-called imperative movements and the epileptic phenomenon of running, is the loss of memory; one has no proofs that there is a loss of consciousness during the running—at least the loss of memory does not imply a loss of consciousness. There are many conditions in which conscious and voluntary acts are performed without leaving any impression on the memory, as in fever, in alcoholic intoxication, in hypnosis, in somnambulism, in sleep, and especially in the so-called epileptic dream-state. That the phenomenon of running sets in in one case of epilepsy and not in another, is dependent upon the intensity and the instantaneousness of the epileptic attack, as well as upon the associations possible under the circumstances, and the degree of consciousness present.

Büttner, in conclusion, summarizes as follows: "(1) The phenomenon of running is not an imperative movement but a voluntary movement, at the most an imperative act; it is not an epileptic coördinated spasm, but a psycho-epileptic equivalent. (2) Procursive epilepsy is neither anatomically nor prognostically a special form of epilepsy. The characteristic symptoms of its attacks are only in form, not in principle, different from those of ordinary attacks, and have no other significance than the well-known automatisms of milder forms of epilepsy."

The literature on procursive epilepsy, quoted by the writers referred to, being already so comprehensive, a single case is not much of an addition to it, still the case, which I am about to report, is so interesting in some of its particulars, that I have thought it worthy of note:

T. E——, 18 years old, born in Kansas, 17 years in California, admitted to the State Insane Asylum, at Stockton, January 25, 1891. No history of neuropathy in the mother's family; on his father's side there is a history of tuberculosis—his grandfather, an uncle, and an aunt died of consumption. The aunt died of consumption two years after her release from an insane asylum, where she had been an inmate for one month. When four or five years old patient fell off a horse, striking his head; was unconscious for thirty minutes; no external wound was produced. The only children's disease he contracted was pertussis. He was a robust, healthy boy, until about five years ago, when he had an attack of "inflammation of the bowels" (enteric fever?), from which he suffered about four weeks.

One year ago he had a fainting spell. He had been playing baseball at school on a very warm day, became overheated and, just as school was called, everything suddenly looked black before his eyes; he fainted and remained unconscious for about ten minutes. He had no spasms and no recollection of anything, except that everything became black. One month after this, when at church in the evening, he had a second attack, which in all particulars was like the first. After this the attacks became frequent, the intervals becoming shorter, until he had as many as six to ten on some days. The attacks became associated with severe pain in the chest, and after them he felt stupid, "half dead," had no ambition to do anything—could sleep all the time. After a time he had spasms during the attack.

About six months ago he had a fit not preceded by aura, except that, as in the first attack, everything suddenly became dark. When he recovered consciousness he found himself in the Los Angeles jail. He had left his home, twelve miles from Los Angeles, and followed the road in the direction of the city, where he was caught, after some hours, by an officer. He had a second running attack in the afternoon about two months ago. He ran about a quarter of a mile when he came upon a horse in the road, mounted it, was thrown off, got on again (of which he afterwards had an indistinct recollection, and which was witnessed by an uncle, who tried to catch him), and rode almost to Los Angeles before he was overtaken by friends and brought back. He did not recover consciousness until some time after he had been brought to the house. On another occasion he ran about half a mile from home before he was caught by his relatives, who said that he was seen to stagger from one side to the other while running, as if drunk; he would run straight for a while, then stagger, stumble, and fall; would get up immediately and run again. He had four running attacks prior to his admission.

When examined at the asylum, the patient was found to be well developed, rather short (5 feet 4¾ inches, weight 128½ pounds), but broad-shouldered and muscular. No abnormalities about the head; hair brown; no beard or mustache; eyes light brown; no scars on body; of a rosy complexion; pulse regular and about 75; intellect normal. He converses freely about his commitment to the asylum, talks rationally and coherently, and says he has come here hoping to be cured of his fits. A few hours after his admission the patient had a light epileptic attack; he lay on a bench when he suddenly rolled to the floor, a slight tremor was present and he doubled up, as if in pain; no frothing at the mouth. When he regained consciousness, he had a severe pain around the heart.

February 6 he had an attack at 6:20 P. M. .He fell, lay motionless about three minutes, arose suddenly and walked from one door to the other, as if trying to get out. He staggered as if intoxicated. His memory was a blank from the moment he fell until he was in bed. After the attack he was stupid. February 7—Had a fit to-day after dinner. He was unconscious for about five minutes; lay quiet during attack. February 9—He had two attacks this morning like the one on February 7; they were fifteen minutes apart.

February 10, treatment was commenced with bromide of potash, 30 grs. three times daily. He had no attacks from February 9 to March 3, when he had an attack similar to the previous ones. March 6 he was walking in the grounds of the asylum, when he suddenly fell to the sidewalk, became unconscious for a few minutes, then arose and ran at full speed across the street, looking behind him in a frightened way, and whispering: "There they are again." He entered the office, ran up the stairs, arrived at the landing of the second story, he fell prostrate against the banister, and would have fallen to the ground if an attendant had not been ready to catch him. In two or three minutes, however, he liberated himself from the attendant's hold and ran into the ward where he belonged, and hid under a bed. The course he had taken was the shortest way to the room he occupied. He was put to bed, and here had two more fainting spells; he would become quiet for a few minutes, be prostrated as if in a faint and with stertorous breathing. After this he would become violent, would strike and bite at two attendants, who held him to prevent him from starting on a run again. Every now and then he jumped up saying: "They are after me again, the rascals; stand by me boys; I must get away from here." The excitement lasted about 30 minutes.

March 30 he had a fit in his room in the evening. He "dropped like a log" the attendant said, and shortly afterward commenced to run around the room, saying: "There they are, the rascals; the scamp is after me because I took his wife down town." When spoken to in this condition he does not answer questions, but only repeats the above sentences. The dose of the bromide was now increased to 180 grains *per diem*. From this date—March 30 to April 13—he had a number of very mild epileptic attacks, not followed by excitement. As he appeared to be getting more and more stupid, the dose was now reduced to 120 grains.

April 25 he had a severe attack. While he lay on the ground, after falling, he had spasms of both superior recti muscles. He arose suddenly and attempted to run, struggling to get away. He had attacks similar to this on May 8 and 9. The latter attack happened in the yard. The convulsions lasted but a minute, at the end of which he suddenly arose, ran in the direction of the wall, but diminished his speed just before reaching it. The patient then had no attacks for over six weeks.

June 28 he had a very severe attack in the evening, lasting nearly two hours. The attendant heard a noise in the room, and, when he reached it, he found the patient running from one side of the room to the other. He acted as if fighting some one; he raised his hand to strike with great violence, but before the hand struck the wall the force of the blow was much reduced. He was cursing some one, mentioning a certain name, because he had shot his dog, swearing vengeance and threatening to kill the person, repeating the curses and threat again and again during the whole attack. Both eyes and the head were turned to the right. When, after he had regained consciousness, he was told what he had said during the attack, he recognized the account, and said it was a correct one in every particular of an incident which happened to him two or three years ago; he had, however, no recollection of the hallucinations during the attack. From June 28 to July 22 he had in all 18 severe attacks like the above, lasting from one and a half to three hours each; he had no light attacks during this time.

On July 17 the treatment was changed to biborate of soda, 10 grs., and tr. cannabis indica, 10 gtt., thrice daily. On July 30, and again on August 20, he had a fainting spell, not followed by running or maniacal excitement. After a free interval of 3 months and 10 days he had a very severe attack (status epilepticus) on November 30 he had seven or eight attacks in succession. During each he would faint, make an exclamation as if he thought he were falling, then the tendons of his right forearm and fingers would contract, the left upper and both lower extremities remaining quiescent, the first time limited clonic spasms in one extermity had been observed. At the same time both eyes, but especially the right one, rolled outwards toward the right side. He would then jump up and try to run, at the same time cursing and making exactly the same threats, using the same words, as on June 28. After the return of consciousness, the right knee-jerk was found exaggerated. December 1 the dose of the borax was increased to 20 grs., that of the cannabis indica to 15 gtt. On December 10 he had a milder attack, lasting two hours, during which he repeated the words: "I can have you burned up!" for about 30 minutes. The eyes were turned upwards and to the right, but there were no spasms in the hand.

On January 14, 1892, he had a similar, but still milder, attack of an hour's duration. February 9th the attack lasted an hour. He had no spasms and was not violent. He appeared to be playing a game of base-ball, making gestures now and then, as if catching the ball, trying to run to catch it, and following it with his eyes. When the words he used during the attack were repeated to him after he became conscious, he said the conversation was the same as he had had in the ball game at the school-house, just before his first attack.

On May 20, 1892, he was discharged, improved, having had no mild or severe attacks since February 9.

April 11, 1893, he was recommitted to the asylum after an absence of 11 months. He had had no attacks whatever from the time he left the asylum until 8 days ago. The medical treatment, biborate of soda 20 grs., and cannabis indica 15 gtt. *ter in die*, pursued at the asylum, which he had been told to continue at home, he had only kept up about two weeks after his arrival in Los Angeles. This attack (April 9) was a severe one, followed by maniacal excitement lasting about 5 hours, during which he broke furniture. It required the strength of two or three men to hold him. On the day of examination at the asylum, he appeared as well as when he left the year before; he seemed as bright intellectually as at any time. The same treatment was at once instituted. A little over a month after his return (May 21, at 8:30 P.M.), he had the first epileptic attack followed by an attempt at running and maniacal excitement; he tried to bite and kick his attendant whenever the latter stopped him from running. The attack lasted about an hour.

On June 19, July 19 and July 29, he had on each day a fainting spell, not followed by running or maniacal excitement; he became unconscious for a short time, had pain in the chest, but no convulsions.

On June 26 the medicines were reduced to 10 grs. and 15 gtt., respectively. From this time to date (March 1, 1894) he has had no attacks and has been steadily at work, apparently well. He is still taking the medicines.

We have in the above history a variety of forms of epileptic attacks: Attacks of *petit mal*, as epileptic attacks without convulsions, and epileptic vertigo. Epileptic automatism proper, as when the patient in the second running attack, at his home, seized a horse, tried to mount it, and finally succeeded after being thrown off once. Ordinary epileptic fits, attacks of procursive vertigo (vertige procursif). Epileptic attacks, with or without convulsions, followed by running (procursio-postepileptica), these latter attacks accompanied by maniacal excitement of one or several hours' duration (postepileptic moria) and finally attacks of running, status epilepticus, on March 6 and November 30, 1891.

The case, therefore, gives illustrations of nearly every described form of epileptic attack. The patient repeatedly gave unmistakable evidence of being subject to hallucinations of fear or persecution, not only during the postepileptic moria, when he calls for help and is defending himself against an imaginary enemy, but also during the phenomenon of running, when he, oblivious of what is actually going on around him, has his eyes fixed on some imaginary object back of him, and whispers words indicating the presence of visual and auditory hallucinations of fear. At the same time the patient, though he does not hear words spoken to him, and does not apparently recognize the persons speaking to him, and although his memory is a blank afterward, he seems to some extent conscious, and his acts, within certain limits, under the control of the will; as where he reduces his speed in running, or the force of his blow in striking, before he reaches the obstacle.

With these facts before us, it seems difficult to explain the running phenomenon in this case, directly associated as it is with hallucinations of fear, and forming but a link in the chain of epileptic symptoms, in accordance with the views of Bourneville and Bricon. On the contrary, it appears much more reasonable to suppose that the running phenomenon is but one picture in the kaleidoscopic display of symptoms in epilepsy, differing from other epileptic phenomena only in outward manifestation and not in nature, leading one to presuppose the presence of a different anatomical lesion.

With regard to the treatment pursued in the case, it will have been noticed that bromide of potash did not seem to have any effect upon the epileptic symptoms, while borax and cannabis indica appear to have had a marked influence, as far as one can judge from a single case and from a period of observation extending over two and one-half years.

THE RELATIONS EXISTING BETWEEN THE REGULAR PROFESSION OF MEDICINE AND THE PUBLIC.

By THOS. ROSS, M.D., Sacramento, Cal.

Read before the Sacramento Society for Medical Improvement.

I shall present the subject of my paper under the following heads:

1. What is the regular profession of medicine?
2. What is meant by the public?
3. What has the profession a right to expect from the public?
4. What has the public a right to expect from the medical profession?
5. The relation now existing between the profession and the public.
6. The relation that should exist.

What is the regular profession of medicine? It is the accumulated thought—the concensus of the opinions, experiences, and observations of the brightest minds engaged in the study and practice of rational medicine in all ages. It constitutes a vast army, including in its ranks many of the most intelligent men of all nations—men of high attainments—well grounded in the experiences and observations of medical men from the time of the great fathers of ancient medicine, as Æsculapius, Hippocrates, and Galen, to the period of the fathers of modern medicine, Sydenham, Boerhaave, and Van Swieten, down to the advanced thought of to-day. Self-sacrificing men, who day and night expose themselves to the fury of the elements, brave the dangers of malignant and contagious diseases, when others flee, in order to alleviate suffering and to restore to health their unfortunate, distressed, and sick fellow beings.

At no time in the world's history were diseases treated so intelligently and so successfully as to-day. At no period in the history of man has medical and sanitary science attained such perfection, nor has there been a time when physicians in all civilized countries worked so faithfully, shoulder to shoulder, to prevent disease, by advocating and adopting advanced hygienic and prophylactic measures.

But while all this is true, at no time in the world's history has quackery and empiricism flourished to the same fearful extent as to-day, notwithstanding our improvements in the science of medicine. This is exemplified in the numerous 'isms, 'pathies, healing mediums, clairvoyants, astrologers, Chinese doctors, and christian science people, that are imposed on our credulous and (medically speaking) ignorant public.

The medical profession knows no 'ism or 'pathy. Each physician prescribes the remedies found most beneficial in the treatment of disease, in doses, be they large or small, that he thinks are best suited to the requirements of his patient. The word "allopath" or "allopathic," as it is generally understood, is, therefore, a misleading and offensive epithet, given us by a sect who call themselves homeopaths, and is a palpable misnomer.

Extreme ideas are always erroneous; homeopathy is an absurdity; eclecticism, as I understand it, denounces the use of minerals in the treatment of diseases, and uses vegetable substances exclusively. This is an extreme idea, and consequently is fallacious. All remedies have their proper uses in suitable cases. The various remedial agents taken from the vegetable, mineral, or animal kingdoms are neither wholly good nor wholly bad, but are useful in the treatment of diseases in cases as experience has shown their merits.

I will dismiss this division of my subject by stating that irregular physicians and incompetent persons have practised medicine from the earliest periods, and will continue to practise as long as there are credulous human beings on the face of the earth.

What is meant by the public? It is difficult to give a definition of "the public" that would not be subject to serious objections, including as it does, people of all grades of intelligence and people of none; persons of all imaginable ideas, "wise and otherwise;" individuals of magnificent physique and those, as Osler says "made of poor material," badly gotten up specimens of humanity, frail, rickety, and cranky mortals. For our purpose, however, "the public" means all persons who are not engaged in the practice of regular medicine.

What has the profession a right to expect from the public? The medical profession, whose members daily and nightly make so many sacrifices of health, comfort, and ease to the public—the sick public—has a right in return to expect due appreciation. The medical profession is the guardian of public health, each individual member of which, in these days, is a sanitary evangelist, proclaiming and teaching, without fee or reward, the best means of preventing disease and of preserving health—thus showing their loftiness of purpose. For all of which the regular profession is justly entitled to confidence, esteem, and respect.

The public hae little or no conception of the amount of time and attention each one of us daily gives to the sick, without the hope of remuneration. I believe that the same effort, the same intelligence, faithfulness, and application given by us in the active practice of our profession, if exerted in other callings—as in commercial pursuits—would pecuniarily bring us a far greater reward, besides rendering our lives more pleasurable, by allowing us more time to enjoy the happiness of our homes—our wives and our children.

What the public has a right to expect of the profession.—The public has a right to expect that the profession will keep pace with the times; that each individual member will be conversant with the recent wonderful advancement of rational medicine. It has a right to expect and to receive all the benefits accruing therefrom; that each member of the profession shall use reasonable skill and diligence in the treatment and for the care of the sick.

The intelligent public does not expect impossibilities, but it does expect that each member of the profession shall be familiar with the advancement of preventive and curative medicine.

The Code of Ethics of the American Medical Association so well defines the duties of the profession to the public that I cannot do better than reproduce it here. It says:

"As good citizens, it is the duty of physicians to be ever vigilant for the welfare of the community; to bear their part in sustaining its institutions and burdens; they should also be ever ready to give counsel to the public in relation to matters especially appertaining to their profession, as on subjects of medical police, public hygiene and legal medicine. It is their province to enlighten the public in regard to quarantine regulations; the location, arrangement and dietaries of hospitals, asylums, schools, prisons, and similar institutions; in relation to the medical police of towns, as drainage, ventilation, etc.; and in regard to measures for the prevention of epidemics and contagious diseases; and when pestilence prevails, it is their duty to face the danger, and to continue their labors for the alleviation of suffering, even to the jeopardy of their lives."

The relation now existing between the profession and the public. By reason of the illiberality, selfishness and mercenary spirit of the times, the public looks upon the profession with distrust. If we advocate the passage of laws having for their sole object the protection of the public when sick from the liability of falling into the hands of ignorant and unscrupulous impostors, we are immediately accused of trying to pass "a cinch bill," of "creating a corner in the practice of medicine," and of "feathering our nests."

If, in advocating the sanitary welfare of our city, we urge the healthfulness of the use of clear, pure water for domestic purposes, the people ask: "How much did you get for your advice?" "There is a big steal in it. What share of the spoils did you doctors receive?" and many similar insinuations.

How strange it is? The law provides a watchman at each end of the Sacramento river bridge, to prevent the public from being injured or killed by passing trains. It insists upon the inspection of steam boilers, to prevent people being killed by explosions. It provides for fire escapes in hotels, etc. It does all this for people in health; but as soon as sickness comes, and the river Styx is close by, there are no watchmen there; the law suddenly deserts them, and they are liable to fall a helpless prey into the hands of illiterate and unscrupulous pretenders of the practice of medicine.

On account of our attitude toward irregulars (for whom I have no word of excuse) in refusing to see a patient under their care, even with the consent and wish of the patient, the public accuse us of being illiberal and prejudiced. The irregular always gives his consent, and, on our refusal, informs the patient that we are antiquated, and afraid to meet him. He then gets credit for being liberal, unprejudiced and progressive.

As the object of our profession is the good, the relief, and the cure of suffering humamity, it is well for us to ask ourselves: "Are we doing justice to it, to ourselves, and to mankind, by our present position in refusing to see and help a person, sick and suffering, because he did not have sense enough to first consult a physician?"

This question will be considered at the meeting of the American Medical Association, which convenes in San Francisco on the 5th of June next. A committee on revision of Constitution, By-laws and Code of Ethics of the Association reported progress at the meeting in Milwaukee, in 1893, and recommended the alteration of Article IV, Section 1, of the Code of Ethics to read as follows: "A thorough medical education furnishes the only presumptive evidence of professional abilities and requirements, and ought to be the only acknowledged right of an individual to the exercise and honors of the profession. Nevertheless, as the good of the patient is the sole object in view, and this is often dependent upon personal confidence, no intelligent practitioner, who has a license to practise from some medical board of known and acknowledged legal authority to issue such license, and who is in good moral and professional standing in the place where he resides, shall be refused consultation when it is requested by the patient."

Observe the words "from some medical board of known and acknowledged legal authority to issue such license."

What the relation of the profession to the public should be.—Until the public can realize the amount of arduous study, the close application to duty, and the many dangers that each member of the regular profession has to surmount to properly qualify himself to treat the sick intelligently, it cannot have a correct appreciation of the profession.

Until the public becomes sufficiently intelligent to distinguish between rational and irrational medicine, and to recognize impostors, it cannot distinguish "the wheat from the chaff," and it will continue to commit the grave error of sacrificing lives to ignorance, incompetence and imposition.

Our efforts should be continuously exerted to teach the public how to recognize impostors and thereby protect itself from a scourge more fatal than small-pox, cholera, or the plague.

By a proper education of the public, on one side, and by the regular profession being composed of all that is meant by the words, *educated and competent medical gentlemen*, on the other, the relation of the public to the regular profession of medicine will be as it ought to be—that of confidence, appreciation and respect. To this end, it is the duty of the profession to direct its best energies.

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DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and
HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Treatment of Acute Metritis.—DR. LUTAUD thus formulates the treatment of uncomplicated inflammation of the uterus, unconnected with the puerperal condition: (1) In the acute period absolute repose, the application of laudanum poultices to the abdomen, warm and frequent vaginal irrigation with a liquid or slightly aromatic emollient. The following solution is at once aseptic and soothing:

Chloral,	
Naphthol,	
Alcohol	āā gm. 10
Water	gm. 190

One tablespoonful to a quart injection. After each injection apply to the cervix a cotton tampon saturated with—

Glycerine	gm. 30
Iodoform,	
Chloral	āā 1

Blisters on the abdomen are advisable whenever pain is severe, and there are indications of peritoneal inflammation. They should only remain in place 8 or 10 hours, and in moderate cases flannel compresses, saturated with alcohol or with spirits of turpentine, are preferable. Flatulence and constipation are frequent symptoms of metritis, which may be relieved by the following prescription:

Chloroform	gm. 1
Tincture of Anise	gtts. x

One coffeespoonful every half hour. Food should consist principally of liquids. Opium is only indicated when there are symptoms of peritonitis. Local applications should be reserved for cases of chronic and subacute metritis. In brief, the treatment of acute metritis may be summed up in these four indications: sedatives, laxatives, complete rest, and frequent vaginal irrigation.—*Journal de Médicine de Paris*, February 11, 1894.

The Influence of Single Ligature of the Cord upon Delivery.—Single ligature of the umbilical cord is advisable: (1) Because it hastens delivery. (2) Because it promotes expulsion of the placenta. Double ligature is indicated only in cases of twin or multiple pregnancy.—*Bulletin Général de Therapeutique.*

The Alimentary Regimen in Neurasthenia.—Neurasthenic patients generally eat too much. Urology shows that with them elimination is slow, consequently the amount of food taken should be reduced to what is strictly necessary. We may reach an approximation of the necessary quantity by lessening the normal amount, and observing the variations in the weight of the patient. It will diminish at first, then usually remain stationary after ten or fifteen days, when we may conclude that the prescribed allowance is sufficient. If, on the contrary, weight and strength continue to grow less, the amount of food taken must be increased. Food should be easy of digestion, and agreeable to the tastes and habits of the patient. Broiled or roasted mutton, fish, ham, eggs, potatoes, green vegetables, gruel, rice cakes, coffee with milk, milk, cooked fruits, may be used moderately, but bouillon, fat, condiments, and salted butter must be avoided. Allow the smallest possible quantity of bread. Albuminoids should constitute one-sixth of the whole. Three meals a day should be taken—as far apart as possible, the principal one in the middle of the day, and the last two or three hours before bedtime. Neurasthenic patients eat too much, but do not drink enough. Water is the most desirable beverage, and three pints a day should always be advised. This quantity increases excretion and elimination, assures arterial tension and irrigation of the tissues. Weak tea may be used in moderation, and mineral waters are beneficial when they do not contain too much iron and carbonic acid. Milk should never be considered a beverage. Neurasthenic cases may be divided into two classes: (1) Patients with a certain degree of *embonpoint*, who lose weight through this regimen, but who are undisturbed by the loss, because they become stronger and more active. (2) Patients more or less emaciated, whose weight is increased by the same treatment, thus showing that emaciation does not always indicate increased administration of food. On the contrary, enlarged alimentation is contra-indicated: (1) Because the system only assimilates what it needs. (2) Because functional energy is not in proportion to the quantity of food consumed. Doubtless, the administration of a large quantity of food is usually followed by temporary stimulation. Meat especially produces this effect. But this is not strength; it is a useless expenditure of strength in the elaboration of food that will never be assimilated. Proportional depression always follows temporary stimulation. Thus we may affirm that among the varieties of overwork to be avoided by neurasthenic patients, digestive overwork is the most dangerous. Generally speaking, the regimen of neurasthenic patients may be regulated by this precept: a minimum of food, with a minimum of digestive labor.—*Gazette de Gynécologie*, February 1, 1894.

Abdominal Support in Pregnancy and in Large Abdominal Tumors.—The medical profession unanimously recommends the use of an abdominal bandage in pregnancy and in large abdominal tumors, as a means of preventing relaxation of the abdominal walls, which sometimes causes eventration of the abdomen, umbilical hernia, hernia at the linea alba, as well as dyspepsia, gastralgia and nervous affections of the digestive tract; but the difficulty of procuring suitable and comfortable bandages has made it almost impossible for patients to follow this advice. Now, however, the new abdominal bandage, invented by VERTUS, seems to fulfil the necessary indications. It consists of two parts: a corset and a bandage; the corset, made of very elastic material, is so constructed that it cannot constrict the chest or the waist, and the bandage deserves special attention. In the region of the hypogastrium it is made of an elastic webbing, which lightly supports the abdomen without constricting it. Laterally it is formed of a band of material similar to that composing the corset, and furnished with a double row of eyelets, so that it may be enlarged at will. Instead of depending upon the loins for support, its upper border is buttoned to the corset so that it drags upon no particular point, but is held up by the entire trunk. Buttons and lacings are so arranged that the patient can easily adjust it herself. Physicians cannot be too strongly urged to advise the use of this bandage. Its employment in every case has achieved the desired results.—*Gazette des Hôpitaux*, February 8, 1894.

Gynecological Relation of Pseudo-Membranous Enteritis.—The study of this disease in the Polyclinic of Bordeaux has led DR. MONOD to the following conclusions: (1) Pseudo-membranous enteritis often complicates diseases of the uterus and its annexes. (2) This affection constitutes a variety of chronic colitis, and its seat is the large intestine. (3) Habitual constipation and persistent neuropathy are symptoms of this complication. (4) Pseudo-membranous colitis may exist with the affection known as pseudo-membranous dysmenorrhea. (5) In some cases pressure of the retroflexed uterus seems to be the exciting cause; in others, uterine or peri-uterine inflammation has probably extended to the large intestine. (6) Whatever the pathogeny of this affection, we should not ignore the possibility of its existence when determining the cause of persistent abdominal pain in cases of metritis, perimetritis, or uterine deviation. Careful analysis of the symptoms often shows that, in many women, pain, which seems *a priori* to be caused by the condition of the uterus or its annexes, really proceeds, wholly or in part, from the digestive tract.—*Gazette de Gynécologie*, February 15 1894.

SURGERY.

By T. W. Huntington, B.A., M.D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and

G. F. Shiels, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

Skin-Transplanting without a Pedicle.—The successful restoration of the skin, after traumatic injury or operative removal, to its normal condition is a subject of wide interest. The work done in this direction by Krause (*Arch. für. klin. Chir.*) is noteworthy. He has within the past two years transplanted over 100 grafts in 21 different cases; of these only 4 grafts entirely died. It does not matter how large the pieces are. Spindle-shaped strips, 8 to 10 inches long and 2½ to 3 inches wide at their widest parts, heal as easily as smaller ones. The main points in the production of good results are perfect asepsis, dry wounds, and a dry graft. The author's method of operation is as follows: The field of operation—either a fresh wound as after the removal of a tumor, or converted into a fresh wound by curetting—must be made antiseptic, preferably with sublimate solution; the antiseptic must then be completely washed away by a sterilized salt solution, and the wound dried with sterilized gauze. From this point the wound, the instruments, and the hands of the operator must be aseptic and dry. If the wound is an old one, in which scar and other fibrous tissue has developed, all such tissue must be removed and only normal tissue remain. The same holds good for operations over the tibia; if there is thickening, it must be chiselled away. The field of operation is then covered by a compress and tight-fitting aseptic gauze bandage. The skin that is to be transplanted is now thoroughly cleansed and made aseptic. Too much rubbing should be avoided; the sublimate should be entirely washed away with the sterilized salt solution, and the skin made perfectly dry. In this case, as in the other portion of the operation, the operator's hands and instruments must be dry, and asepsis, not antisepsis, used. The anterior and inner surfaces of the arms and thighs are to be used, as also that from the glutei. The strips taken should generally be spindle-shaped, as such wounds are more easily closed, and should be afterward trimmed as required. The section is cut out and then dissected up, the knife being held perpendicular to the flap. The layer of connective tissue between the skin and subcutaneous fat should be dissected up with it, but it makes no difference if small particles of fatty tissue come with it. This graft or skin-flap is then dried by aseptic gauze compresses, with, perhaps, the arrest of the slight hemorrhage by torsion. It is immediately placed upon the already prepared wound, after the necessary trimming to make it fit, and is held in place by an aseptic gauze compress until it is fixed in place by a thin film of coagulated blood. Stitches are not needed, except, perhaps, in the face, and only act as foreign bodies. The dressing consists of five-per-cent. sterilized iodoform gauze, placed smoothly over the wound and fixed in place by the gentle pressure of an aseptic dressing, and, if the case is on a limb, a splint. The first change of dressing is on the third or fourth day, when blisters will be found upon the transplanted graft, which must be carefully cut away. In order that there may be no injury to the graft, only the first bandage should be removed, and the limb then placed in a boric acid bath. In facial operations the iodoform gauze must be thickly spread with borated vaselin, and in all cases great care must be exercised in changing the dressings. The appearance, at the end of four days, is white, or, if soaked with blood, purplish and livid; at the end of seven or eight days there is a rose tint, which becomes more marked at the end of two weeks, especially when the exfoliated epidermis has been cleared away. There are sometimes slight superficial necroses that quickly heal over. The transplanted skin heals over any underlying normal tissue equally well. Complete healing occurs in from three to six weeks, depending on the underlying tissue and the age and condition of the patient. As the entire skin is used, eyebrow defects can be supplied by transplanted scalp. The skin is movable after healing has taken place, while microscopical examination 22 days after operation showed normal adipose tissue.—*American Journal of Medical Sciences*, February, 1894.

The Etiology of Carpal Ganglia.—LEDDERHOSE (*Deutsche Zeitschr. für. Chir.*) discusses this subject at length, from its pathological, anatomical and histological sides. His researches on the etiological side of the question lead him to these conclusions: (1) The ganglion takes is origin in the groove found in every normal hand, in which lies, upon the capsular ligament of the joint, a mass of fat and connective tissue that is the true source of origin of the ganglia. After attaining a certain size it seeks the surface, and reaches it generally in front of the ligamentum carpi dorsalis, between the tendons of the extensor indicis proprius and the extensor carpi radialis brevis, or sometimes the extensor pollicis longus; it can, however, reach the skin between any of the other neighboring tendons, or even through the ligamentum carpi dorsalis. The literature shows that by means of a longer or shorter pedicle extending out over the side these growths may reach the volar side of the wrist-joint. Whether the majority of ganglia of the volar region originate thus is doubtful, but the author's material shows that they can arise directly from the volar aspect. (2) Nothing in his researches tended to prove that the ganglia have, or at any part of their existence have had, any connection with either the joint cavities or the synovial sheaths of the tendons. In no case was either direct communication or a trace of previous indirect communication found between these structures and the ganglia. Nor was there any histiological likeness in their structure. (3) The typical ganglion is a new-growth, caused by a jelly-like or colloid degeneration of connective tisssue, and the mingling of numerous collections into one. This takes place for the most part in the para-articular tissues, and contusion is usually the determining cause. From the clinical aspect, ganglia have a fixed course of development, come to ripening, as it were, and then often heal spontaneously. Clinically, he would summarize his results as follows: (1) Ganglia change their size easily; they easily change from deep-seated to superficial growths, while secondary cysts empty themselves into older and more superficial ones, and very thin cysts are easily ruptured and then absorbed. (2) Ganglia pass away easily, leaving no trace behind, or only a small, hard swelling. In advanced life they are seldom seen. When they are ripe they are easily ruptured and absorbed. (3) The frequent relapse as seen after all methods of treatment is due to the formation of other cysts that communicate with the original and occasion refilling. The author advises the leaving to nature the spontaneous healing as the best method; but this is not possible in all cases, and in these cases, as well as those where the patient demands a speedy removal of the tumor, he advises excision, with incision of all the surrounding structures, or incision, curetting, and packing with tampons.—*American Journal of Medical Sciences*, March, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

School Ophthalmia.—Jonathan Hutchinson, in a paper on the subject of school ophthalmia, formulates the following propositions: (1) That the contagious ophthalmia, which recently prevailed to a greater or less extent in certain high-class schools, is precisely the same malady as that which in pauper schools has long been recognized as the origin of trachoma. (2) That the reason why few cases of trachoma resulted from these outbreaks is that efficient treatment was adopted. (3) Neglect isolation, and school ophthalmia will spread through the establishment. (4) Neglect local treatment of school ophthalmia and a certain number of trachoma cases or "workhouse ophthalmia" will result. (5) A certain number of protracted trachoma cases have already resulted from ophthalmia epidemics in middle-class schools, and a far larger proportion of cases would have passed into this stage had it not been for careful treatment. (6) It is a feat of clinical imagination to conceive that there are two forms of epidemic follicular ophthalmia, one of which has no tendency, when neglected, to end in trachoma. (7) "Follicular conjunctivitis," or "follicular ophthalmia," are names for early stages of granular lids. This stage is characterized by general enlargement of the normal follicles, and often of the papillæ also. (8) It is admittedly extremely difficult to say in slight cases whether enlarged follicles are a personal peculiarity, or an evidence of disease. (9) "School ophthalmia" is a name for a contagious, and often very brief form of conjunctivitis, which, if neglected, may in certain cases produce granular lids. (10) "Workhouse ophthalmia" is a name for advanced cases of granular lids (trachoma). It is always initiated by an attack of school ophthalmia. (11) The disease known as catarrhal ophthalmia, which often runs through families, and is attended with patchy congestion of the ocular conjunctiva, may be the same disease as school ophthalmia. (12) School ophthalmia is, however, rarely attended with much congestion of the ocular conjunctiva. (13) The initial attack is usually easily and completely cured by local treatment. (14) The second stage of follicular ophthalmia is usually curable by efficient treatment, perseveringly used for a month or two. (15) The third stage, that of trachoma, when the conjunctiva is thickened and the follicles excessively implicated, is curable with great difficulty, is very likely to relapse, and often requires treatment extending over years. (16) In all stages those who suffer from granular lids are liable to relapse, and to become sources of danger from contagion. (17) The danger of contagion is probably in proportion to the amount of puro-mucous secretion. During the conditions of dry eye, with little or no secretion, such cases are probably but little dangerous. (18) School ophthalmia by no means always leads to granular lids. On the contrary, a large majority of its subjects recover completely; such recovery is almost universal under efficient treatment. (19) There is, however, always a risk that school ophthalmia may, if neglected, and in certain constitutions, run into granular lids. (20) Conversely, cases of granular lids are, in all stages, if temporarily attended with discharge, liable to become sources of epidemics of school ophthalmia. (21) It is probable that all epidemics of contagious ophthalmia in schools are the same in kind, although they may, in accordance with the general law of epidemics, differ widely in severity. (22) The tendency to develop granular lids, after an attack of school ophthalmia, probably depends much upon the race-descent, structural endowments, and state of vigor of the patient. (23) All cases of trachoma have been preceded, in the first instance, by an attack of conjunctivitis, due to specific contagion. (24) The initial attack of conjunctivitis is, in its nature, transitory. It is often slight, and lasts only a week or ten days. (25) After the initial attack the conjunctiva of the globe may resume a normal condition, whilst changes are going on insidiously in the follicles and papillæ. School authorities should require a certificate of freedom from ophthalmia on the return of a pupil to school. In case anyone is suffering from "sore eyes," isolation should be immediately adopted and advice obtained. If, in any case, relapses occur and granular lids are developed, the isolation and treatment ought to be prolonged, and the pupil ought not to be allowed to return to school.—*Lancet*, February 10, 1894.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. Simmons, Jr., M.D., Sacramento, Cal.

Leprosy in India.—The following order has been passed by the government of Madras: "The report of the Leprosy Commission, and the conclusions as to the disease which are embodied in it, form, in the opinion of the government, sufficient ground to warrant the refusal to assent to any measures of compulsory segregation, or of isolation and supervision of lepers in their homes, such as are advocated in the proceedings of the Committee of the National Leprosy Fund. His Excellency in Council approves of legislation for carrying out proposals (*a*), (*b*), and (*d*), made by the Commissioners, and for removing any obstacles in the existing law to the employment of local or municipal funds in the establishment and maintenance of leper asylums. But, while removing any such obstacles, this government would not make provision for these purposes in any way compulsory, or exercise any pressure in that direction upon local bodies. Considering the very infinitesimal danger of contagion and inoculation, and the apparent decrease of the disease, and considering also the imperfect provision for general medical relief, and for other objects of equal consequence, which the state of their funds enables local bodies to make, this government would leave the provisions of asylums for lepers mainly to private charity."—*British Medical Journal*, January 27, 1894.

Treatment of Warts by the Internal Administration of Arsenic.—Sympson contributes an article on this subject in the *Quarterly Medical Journal*. Though warts sometimes disappear spontaneously without any treatment whatever, and although the treatment of them by various kinds of outward applications is often perfectly successful, yet quite enough cases are found apparently intractable by ordinary methods to justify a short note on the use of a drug which seems specially adapted to cure this tiresome and vexatious complaint. First a word or two as to local remedies. The writer has tried, on different patients, nearly all the drugs usually recommended for the abolition of warts. Such are glacial acetic acid, salicylic colloid, fuming nitric acid, carbolic acid, liquor potassæ, and argenti nitras. The first two named on this list seemed to act best, and the salicylic colloid he prefers of the two, as most easily applied by any unskilled person and least irritating to the patient. But for the last few years, acting on a suggestion in an American medical journal, and on account of Mr. Pullen's paper (*Practitioner*, 1888, vol i, p. 207), in every case of warts which did not show some sign of yielding to these applications in ten days or a fortnight, he prescribed small doses of arsenic internally. Of its rapid action on the warts there can be no doubt whatever. He has repeatedly tried it by itself, and by the end of a fortnight even a large crop of warts will have disappeared. An advantage also of its use alone is that by children (who are, of course, the chief sufferers from warts) any kind of caustic or painful application is much dreaded; also very little arsenic need be given. The drug need not always be given as long as a fortnight, for a week's treatment by small doses twice a day seems to set up a healthy action in the warts, which is continued after the medicine has been left off. The combined treatment, though, of arsenic internally, with salicylic colloid painted daily on the warts, is quicker than by arsenic alone. The author gives 1, 2, or 3 minims either of the liquor arsenicalis or liquor arsenici hydrochlor. twice or three times a day, according to the age of the child, and has never found it needful to exceed the largest dose. He has never found any symptoms of its disagreeing with the patients. Its action on the warty growth is no doubt due to the increased metabolism of the skin, leading to these hypertrophied portions being killed and exfoliated. It is somewhat curious to note that arsenic has been accused of producing warts.—*Therapeutic Gazette*, February, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Salipyrin in Influenza.—VON MOSENGEIL, after an experience of two and a half years, strongly recommends salipyrin as a remedy in influenza. During this period he has found the drug to be a specific in that affection. It must be given on the appearance of the first symptoms of the disease. In the case of young children doses of from 2½ to 4 grains are generally sufficient; to older children, and to persons of light body-weight or extraordinary susceptibility to drugs, 7½ grains may be given; while if the patient be very strong, or if the attack be very severe, and especially if it has lasted several days, 15 grains should be given. Even after the administration of repeated daily doses of 30 to 45 grains, Von Mosengeil has not seen any unpleasant secondary effects. Salipyrin is of least service in the cases of influenza characterized by the rapid development of small circumscribed patches of pneumonia. In such cases large doses—25 to 30 grains, 3 times daily—are required. The author is emphatic in insisting upon the continuance of the remedy for some time after the apparent cure of the disease, in order to prevent relapse. It is important that food should not be taken for about two hours before and after the administration of salipyrin. If violent fever be present, very large doses—45 to 75 grains—should be given, or salipyrin may be given alternately with quinine in doses of about 8 grains. Von Mosengeil, in such cases, gives quinine in the morning and salipyrin in the evening. If the latter alone be used, it is best given in the evening. He also speaks well of salipyrin in ordinary colds; it should be taken as soon as the chill is experienced. He has also found it useful in certain forms of rheumatism.—*British Medical Journal.*

Phenocoll in Malaria.—PIETRO PUCCI confirms the statements of Albertoni as to the curative effects of phenocoll in malaria. He believes that the drug is best adapted to those cases in which the administration of quinine is followed by ictero-hematuric fever, characterized by severe rigor, vomiting, hematuria and jaundice, or by simple hematuria and subcutaneous hemorrhages. In such cases phenocoll is an effective substitute for quinine, cutting short the malarial fever without causing any of the symptoms which have been mentioned.—*British Medical Journal.*

Piperazine in Gout.—BIENSENTHAL has experimented with piperazine in animals. He procured artificial deposits of urates in the heart, pericardium, bladder and kidneys of 112 animals, 29 of which were treated with piperazine, 36 with various other substances, while the others served as control subjects. The drug was administered in the form of pills, the maximum dose being 0.75 gm. a day, or in subcutaneous injections. The animals were killed from two to seven days afterward, when no trace of deposit was found in their organs; whereas, those treated with borax, lithia and phosphate of soda, were found to have numerous deposits. The author concludes that piperazine is the best solvent for such deposits. He further states that albuminuria was not met with, and believes that Roehring mistook a precipitate produced by picric acid and piperazine for albumin.—*British Medical Journal.*

Chlorobrom in Sea-sickness.—DR. JOHN A. BOYD relates his experience with the use of chlorobrom in the treatment of sea-sickness. He recommends that the bowels be freely moved before embarkation, and that during the early part of the voyage the passenger abstain from soups, vegetables and pastry. A teaspoonful of chlorobrom each night for the first three or four nights is an excellent prophylactic, and larger doses will relieve the patient even after the sickness has commenced.—*Lancet.*

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Traumatic Neurosis.—STRUEMPELL, of Urlangen, includes under this designation, functional diseases in contradistinction to traumatic organic diseases of the nervous system. Patients who suffer from traumatic neuroses have sustained, previous to their sickness, a lesion. The immediate effects of the lesion have long since disappeared, but the patient, since the receipt of his injury, has never regained his former functional activity. The point of lesion is usually the starting place for the affection, and every region of the body may be the seat of abnormal subjective sensations although the pain is rarely localized and is almost never confined to the course of special nerves. Aside from the abnormal sensations; there are decided functional motor disturbances. The extremities are moved with difficulty, the patients are easily tired, have lost their energy, complain of head pressure, cloudiness of the senses, insomnia, anorexia, and cardiac palpitation. Other symptoms may be elicited by questioning the patient. In contradistinction to the numerous and varied subjective sensations, the objective examination furnishes but few positive signs. The point of lesion may still be painful, but beyond this nothing else is noted. The visceral examination yields nothing. Certain symptoms, specially studied by Oppenheim, are prominent in traumatic neurosis. There is slight psychical depression of an hypochondriacal, melancholic character, sensorial anesthesia of the skin and visual apparatus, motor disturbances, in part pareses, in part irritative manifestations, such as cramps and tremor; further, vasomotor and secretory disturbances, such as increased frequency of the pulse and hyperhidrosis. These symptoms are not constant and may be absent. It has been assumed that traumatic neurosis owes its origin to purely mechanical effects of the traumatism, such as rupture and stretching of the muscles and nerves, small bone splinters compressing the nerves; this view, however, is not tenable. The origin has also been attributed to a concussion of the nervous system, especially the brain and spinal cord. While it is true that concussion of the brain may produce death, and at the autopsy no definite lesion can be demonstrated, in traumatic neurosis, however, the lesions have, in many instances, been so slight that concussion could be excluded without question. On account of the resemblance of this disease to hysteria and neurasthenia, it is customary to refer to it as an hysterical effection. Simulation of traumatic neurosis does not often occur. In the discussion of the paper, WERNICKE referred to 100 cases of traumatic neurosis which had come under his observation. His conception of the affection was a functional nervous disease without an organic substratum. He opposed the theory of Oppenheim, who supposes that in traumatic neurosis, there is implication of the motor and sensory cortical centers. The theory of Charcot, that the affection is nothing but an hysteria of traumatic origin, was opposed by the speaker. Hysteria is only a generic term for a series of pathological pictures. Simulation in traumatic neurosis is in the direction of exaggeration; he has seldom observed true simulation. Many examinations necessarily have a suggestive action. In cases showing no pupillary reaction, inequality of the pupils, paralytic disturbances in speech, increased tendon reflexes, diminished electric irritability, etc., simulation can be excluded. Unverricht recommended the use of chloroform to detect simulation. In one case of complete hemianesthesia, with a small anesthetic area on the opposite side of the body, the most intense irritation could not produce pain, as determined by the facial expression. To this patient chloroform was administered by inhalation until the sensorium of the patient was cloudy, when simulation was detected.—*Wiener med. Presse.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Insanity from the Abuse of Indian Hemp.—In the Section of Psychology, at the last meeting of the British Medical Association, DR. THOMAS IRELAND said that the excessive use of Indian hemp, or cannabis indica, has long been recognized in eastern countries as one of the most common vices, and as a very prolific cause of insanity. It has been introduced into British Guiana and the West Indies by the East Indian coolie immigrant. The vice was almost entirely confined to the male sex and to Hindoos, the Indian Mohammedans being rarely addicted to it. In British Guiana fully 30 per cent. of the coolie patients admitted to the Berbice lunatic asylum show a history of having been habitual smokers of the drug. The cheapest and commonest form in which Indian hemp is prepared is known as bhang; it produces a quiet and pleasant delirium and stupor. Churrus, the name given to the dried, sticky resin, causes excitement, attended with violence. The drug is also used in the form of a sweetmeat, called majoom, and smoked as ganja, made from the dried flower-tops; this latter preparation is the one generally employed by the coolies in British Guiana and the West Indies. The mental symptoms presented by those using the drug to excess belong to various types of insanity; as yet no special pathological changes have been observed in such cases, except the common occurrence of asthma among ganja smokers. Dr. Ireland illustrated his remarks with a clinical history of three typical cases of the extreme forms of insanity. The first was one of acute mania, with homicidal impulse; the second a case of acute melancholia, with attempted suicide; and the third one of chronic dementia.—*British Medical Journal.*

The Effect of Rest in Bed upon Epileptics.—DR. C. NEISSER has recently reported observations made on the effect of rest in bed upon epileptics. Seven chronic cases of epilepsy, most of the patients being demented, were put to bed in a dormitory, and the rest in bed remained undisturbed, except on fine days, when the patients were made to take a one to two hours' walk in the garden. A gain in weight was the result in all the cases after the first week, the increase in weight continuing for four weeks, and after that was subject to variations; at the same time the epileptic attacks showed a considerable decrease in number in six of the patients, though this improvement was only temporary. Psychic disturbances, however, which presented themselves in connection with the convulsive attacks, were made decidedly milder by the rest in bed. The author believes that in cases in which one can at all expect to obtain a cure the beneficial effect of the bromide preparations should be aided by rest in bed.—*Therap. Monatsh.—New York Med. Monatschrift.*

Glycosuria in Cerebral Apoplexy.—DR. M. LOEB reports two such cases, first calling attention to the opinion of Prof. v. Jaksch, of Prague, expressed in a recently published lecture, that the occurrence of transitory glycosuria in cerebral disease is quite rare. Prof. v. Jaksch further says that the majority of the reported observations are uncertain on account of the employment of not altogether faultless methods, and that he has never seen glycosuria in a fresh case of hemiplegia. In one of the cases reported by Dr. Loeb glycosuria had been observed after two apopletic insults separated by an interval of a year, occurring in a man 52 years old. In each instance the glycosuria lasted for days, and was determined quantitatively. He is of the opinion, after a careful study of the literature on the subject, that glycosuria can only occur in diseases located in the neighborhood of the fourth ventricle. In connection with the statement of Prof. v. Jaksch, Dr. Loeb further directs attention to six cases reported by Frerichs, in which the amount of sugar was also determined quantitatively.—*Centralblatt f. klin. Medicin.*

FORMULÆ.

By GEO. B. SOMERS, M. D., San Francisco, Cal.

Spiced Plaster.—Cataplasms of aromatic powders are excellent for use as mild rubefacients, especially in nausea and vomiting, being applied over the epigastrium. The following is commonly used:

Ginger.	
Cloves.	
Cinnamon.	
Black pepper	āā ℥i
Tinct. ginger	ʒss
Honey	*q. s.*

Mix the powders and then add the tincture and honey so as to form a stiff cataplasm.

Warts.—MORISON applies:

Hydrarg. bichlor	gr. v
Ac. salicyl	ʒi
Collodion	℥i

S.—Apply once a day, the upper crust of the previous application being removed before a fresh one is made.—*Medical News.*

Two Tonics:

I.	Wine of kola.	
	Wine of quinquina.	
	Gentian.	
	Colombo	āā ℥viii
	Fowler's solution	gtt. x
	Tinct. nuc. vom.	gtt. v

S.—Take at each meal a wine-glass of this solution.

II.	Ext. quinquina.	
	Ext. kola	āā gr. lxxv
	Ext. rhubarb	gr. xxxvi
	Ext. nuc. vom.	gr. viii
	Arsenite of iron	gr. iii
	Powdered kola	*q. s.*

For 100 pills.

S.—Take two pills at each meal.—*Novueaux Rémèdes.*

Ipecac. for Insect Bites:

Powdered ipecac.	
Alcohol.	
Sulphuric ether	āā ℥ss

S.—Apply on the affected parts.—*Union Médicale.*

Salicylate of Soda as a Wash in Articular Rheumatism:

Salicylate of soda	ʒ iss to ii
Laudanum	mxx
Distilled water	℥ iii

S.—For a wash.

N. B.—The results obtained were the same as if salicylate of soda had been administered by the mouth.—*Nouveaux Rémèdes.*

Hyndeman's Cough Drops.—The following is said to be the formula of the so-called "black-bottle:"

Cod-liver oil	℥ v
Gum arabic in powder	gr. lxxv
Mucilage	℥ i
Comp. spirit of lavender	ʒ xviii
Spirit of peppermint	ʒ xviii
Syrup of tolu	℥ ii—M.

—*National Druggist.*

PUBLIC HEALTH.

By W. R. Cluness, M.A., M.D., San Francisco, Cal.

Mortality for February, 1894.—The deaths registered in 89 town districts of the State, during the month of February, in a population of 807,132, correspond to an annual rate of 15.00 a thousand, the total mortality having been 1,011. 53 deaths were due to zymotic diseases, giving an annual rate of .78 a thousand. Of these, 9 were due to diphtheria, 4 to cholera infantum, 14 to typhoid fever, 2 to diarrhea and dysentery, 5 to cerebro-spinal fever, 7 to whooping cough, 7 to croup, 1 to intermittent and remittent fevers, 4 to scarlet fever, 0 to measles, and 0 to small-pox. 344 deaths resulted from diseases of the respiratory organs, giving an annual rate of 5.04 a thousand. Of these, 205 were due to consumption, 98 to pneumonia, 31 to bronchitis, and 10 to pulmonary congestion; the rate being, for consumption and pneumonia, 3.00 and 1.44, respectively. 86 deaths resulted from diseases of the heart, 4 from alcoholism, 2 from erysipelas, 25 from cancer, and 445 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 576,000, was 16.08. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Stockton.

METEOROLOGY.

Summary for February.—*Temperature.*—The normal temperature of the State for February is 49°, the average for February, 1894, was 46°; a departure from the normal of 3°. The highest monthly mean was 57°, at Belmont and Palm Springs; the lowest, 24° at Cisco, Summit and Truckee, in the high mountain regions of Nevada and Placer counties. The maximum temperature was 90°, on the 27th, at Indio and Volcano Springs, San Diego county; the minimum, 15° below zero, at Truckee (5,819 feet above the level of the sea); The greatest monthly range was 72°, at Weaverville; the least, 24°, at San Francisco and Point Reyes.

Rainfall.—The normal precipitation for the State for February is 3.56 inches; the average for February, 1894, was 3.47 inches; a departure from the normal of —0.09 inches. The greatest monthly precipitation was 16.48 inches, near Meadow Valley, Plumas county; the least, $\frac{1}{12}$ of an inch, at Needles.

Wind.—The prevailing direction of wind was westerly and northwest.

Unusual Features.—The unusual meteorological feature of the month was the great departure from the normal rainfall in Southern California to what it is in the northern and central portions of the State; and also, to the continued departure below the normal temperature, for the entire State.—James A. Barwick, Director California Weather Service.

California—Tabular Statement for February, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No. of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn..........Cal.	48.0	75.0	29.0	------	------	------	----	9.89	------	----	----	----	S.W.	Southern Pacific Company.
Berkeley......... "	45.0	60.0	34.0	53.0	41.0	12.0	11	3.77	84.0	14	3	11	N.	Obs. University of California.
Colfax............ "	42.0	80.0	28.0	------	------	------	----	9.16	------	----	----	----	S.W.	Southern Pacific Company.
Eureka........... "	44.0	56.0	29.0	50.0	37.0	13.0	13	1.13	86.0	10	4	14	S.W.	Weather Bureau Dept. Agr.
Fresno............ "	47.0	69.0	30.0	56.0	38.0	18.0	8	2.02	70.0	9	10	9	N.W.	" " "
Keeler............ "	41.0	67.0	23.0	52.0	30.0	22.0	3	0.29	41.0	19	8	1	N.W.	" " "
Los Angeles.... "	51.0	73.0	35.0	62.0	41.0	21.0	3	0.49	69.0	11	14	3	W.	" " "
Monterey....... "	48.0	66.0	30.0	------	------	------	----	2.05	------	----	----	----	S.	Southern Pacific Company.
Napa........... "	48.0	67.0	32.0	56.0	40.0	16.0	9	2.97	77.0	13	10	5	S.	Station Napa Insane Asylum.
Oakland......... "	48.0	65.0	35.0	54.0	41.0	13.0	13	3.70	92.0	15	6	7	N.W.	Chabot Observatory.
Paso Robles.... "	46.0	70.0	25.0	58.0	34.0	24.0	4	0.59	58.0	13	6	9	S.W.	Agricult. Experiment. Stat'n.
Red Bluff....... "	45.0	67.0	30.0	54.0	37.0	17.0	10	2.30	69.0	9	11	8	N.W.	Weather Bureau Dept. Agr.
Sacramento.... "	47.0	66.0	32.0	55.0	40.0	15.0	9	3.92	76.0	13	7	8	S.E.	" " "
San Bernardino "	48.0	74.0	28.0	61.0	35.0	26.0	3	0.88	65.0	17	7	4	W.	A. K. Johnson, M. D
San Diego....... "	52.0	69.0	34.0	57.0	46.0	11.0	5	0.49	72.0	15	10	3	W.	Weather Bureau Dept. Agr.
San Francisco.. "	48.0	62.0	38.0	53.0	44.0	9.0	12	2.69	79.0	13	4	11	S.W.	" " "
Santa Barbara.. "	51.0	69.0	34.0	60.0	42.0	18.0	4	0.76	70.0	18	5	5	W.	Hugh D. Vail
Santa Cruz...... "	49.0	70.0	32.0	60.0	39.0	21.0	11	8.60	-	16	0	12	S.W.	W. R. Springer.
Yuma..........A. T.	52.0	82.0	30.0	68.0	38.0	30.0	1	T.	47.0	17	10	1	N.E.	Weather Bureau Dept. Agr.

T. means a trace of rain.

Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: APRIL, 1894

STAND BY THE CODE.

In accordance with the recommendation of PRESIDENT MCGUIRE, the question of the proposed revision of the Code of Ethics will soon be submitted to the Medical Society of the State of California for its approval or disapproval. We believe that the Society will speak with no uncertain voice and that it will record its vote as emphatically opposed to any change that will tend to weaken the vital points of this instrument that has for many years served as a guide, and as a rallying ground, for all that has been best in medicine in this country. The reformers representing "progress" demand the revision of an instrument that has become "antiquated" and no longer fitted for "the changed conditions" of medical practice to-day. They desire to see certain safeguards abrogated, and matter, alleged to be useless, abandoned. Before entering into the objections to the Code that have been raised by the agitators of reform, we will give a definition of it from the pen of one, who, more than any other, has been identified with its very earliest history.

In our issue of May, 1893, when discussing the proposed revision of the Code, then under consideration, the following will be found:

"The Code of Medical Ethics of the American Medical Association is a plain, concise and dignified exposition of the mutual duties and obligations of physicians and their patients; of physicians to each other, and to the profession as a whole; and of the profession and the public in its varied organized relations. The sentiments and principles it inculcates are of the most liberal, just and humane character. It enjoins the most faithful and unostentatious aid to the poor and exacts honorariums from the well-to-do, with the utmost kindness toward each other. It exacts obedience to no one theoretical dogma or so-called principle relating to the nature of disease or the action of drugs, but explicitly declares a knowledge of the accumulated facts and experience of the profession as presented in the several recognized branches of medical science and art as the only qualification entitling the individual to recognition as a member of the profession or as worthy of consultation. It allows each member of the profession the utmost liberty of private judgment in the application of remedies in the treatment of his patients, while it, with equal emphasis, prohibits all dealing in *secret* remedies, and all exclusive adherence to such qualifying prefix to the honorable title of physician or Doctor of Medicine, as implies the restriction of practice in accordance with some particular theory or pretended principle, as homeopathic, eclectic, hydropathic, physiopathic, etc. The adoption of such qualifying prefixes inevitably begets and maintains sectarianism and partisanship in the profession, while it bewilders and deceives the non-professional public. Such prefixes are justly regarded by the Code of Medical Ethics in the same light as patent rights and *trade marks* on surgical instruments and vials of medicine."

This was written at our request by DR. N. S. DAVIS, and in another column it will be seen that he finds no reason to withdraw from the position he has held for all the years that comprise the life of the Association. The longer this question remains under debate, and the more we read of the arguments of the reformers, the less importance attaches to this clamor for revision. Simmered down, the effort being made is simply to provide a degree of elasticity in some matters, that the Code, in the rigid integrity of its simplicity, declines to condone. If it were possible to take a plebiscite of the regular profession in this country, we confidently believe that an overwhelming majority would oppose "revision," as the term is generally used. We have already said, and we repeat, that there is no demand of this character from the general practitioners. The advocates for reform are in the ranks of the specialists, and it is satisfactory to know that they are even there in comparatively small force. The element is, however, noisy, persistent, and persevering. For the good of the body politic it is therefore best to administer a substantial rebuke.

Taking up the principal points of attack, we shall first consider the sections relating to the duty of our patients to us. It is often said that the Code being only for physicians, this matter is superfluous. Here again it is very evident that the specialist is speaking. He has not the same intimate relations with his patient that is so universal and so essential on the part of the general practitioner. We most heartily agree with DR. DAVIS that it would be very much better if the public was familiar with the general provisions of the Code, and especially with these sections. In any community containing a well organised medical society, the influence of its teachings regarding the ethical relations of physicians, and the simple rules regulating their conduct in the ordinary matters of professional life, can be most plainly traced. In no case is this the result of special effort; it is simply enforced habit, the outgrowth of custom. It is recognised and passes unchallenged in precisely the same way as an established fee bill. Will any one deny that persistent missionary work would greatly improve these conditions?

The refusal of the Code to sanction a patent on a surgical instrument is the second point made by the reformers. Here it is urged that the physician is needlessly deprived of that which he has an undoubted right to enjoy, the fruit of his brains. It has also been urged that as there is no restriction in the matter of copyrighting books, that a patent on a surgical instrument is no more unwarrantable. We do not think that these cases are exactly parallel, yet we do not apprehend that any great harm can come from conceding this point. As the Code at present stands, the principle is certainly correct. The patenting of any surgical appliance obviously means an increase in its cost and a proportionate hardship to the profession and to the sick under its charge. On the other hand, it is difficult to conceive that an instrument could be devised of such a character that a substitute could not be procured, or that would be so needful as to be absolutely essential to the practitioner. It must also be borne in mind that the greatest number of appliances, and the most valuable, will still be devised by the leaders in the profession, and it is fair to assume that they would not go into the patent rights business, but that it would still be confined to the persons who peddle inferior apparatus of their own device at an exhorbitant price.

The main question at issue is that which relates to the rights of consultation. It is this question that appeals most strongly to our readers. Here we want no compromise; let the line be drawn, as now, with plain directness and free from any possibility of misconception. On this point, as will be seen in another place, the Sacramento Society for Medical Improvement, "the oldest medical organization in California," has very decidedly expressed itself. We confidently expect the same unmistakable language from the State Society. The issue in this case is perfectly clear. Can it be supposed that those who are now secretly violating the Code need such salve for their consciences? Is it fair to ask others to countenance this deception? We want no compromise with quackery, with sectarian therapeusis, or with denominational medicine. The evidence is not wanting that in a few years the 'pathies will have vanished, and that if a distinction is drawn it will be within our ranks between competent and incompetent. Shall we betray the heritage of our fathers? Rather let us maintain a dignified exclusiveness in the pursuit of medical science and medical knowledge, disdaining to acquiesce in such professional contamination as every true physician must despise.

CALIFORNIA NORTHERN DISTRICT MEDICAL SOCIETY.

The semi-annual meeting of the California Northern District Medical Society was held at Woodland, on Tuesday, March 13. The attendance was much larger than had been expected, and the papers furnished were more than sufficient to fill the allotted time. In another column we give a report of the proceedings, and the various papers will appear in due course. It has been decided to hold the annual meeting in Marysville, which may be regarded as the home of the Society. This town is centrally situated and easy of access for a majority of the members, so that an excellent meeting is already assured.

The papers have shown a steady improvement from the earlier meetings of the Society, and the only feature now lacking is the discussions. It is in the highest sense discouraging to an author who has taken pains, and spent time in preparing a paper for his Society, to find that its reading falls flat, and that it is accepted without comment. Members should not wait for an invitation to join in the discussions, but each should endeavor to contribute his mite to the general fund. Several new members were elected and the Society shows, even in these dull times, a very healthy improvement.

One exceedingly regretable feature of the occasion was the very small attendance at the banquet given by the Yolo County Medical Society, at Byrne's Hotel. Owing to circumstances which the Committee of Arrangements was unable to control, the hour fixed was 9 P. M. This would have compelled non-resident members to stop over until the following day, and many of the visitors were unable to do so. It was certainly somewhat ungracious and in some cases not wholly inexcusable, but in future it would be well to guard against such a contingency.

THE STATE SOCIETY.

The twenty-fourth annual meeting of the State Society will be held in Germania Hall, South Second street, San José, April 17th, 18th, and 19th. As we have already stated, circulars have been issued to every member of the profession in good standing throughout the State. In view of the approaching meeting of the American Medical Association, every effort has been made by the President, Dr. C. G. Kenyon, and also by the Secretary of the Society, to induce the largest possible addition to the membership. Any member who is in good standing in his local society, and who has resided in the State for six months, is eligible for membership. Those who desire to join should at once forward their credentials with the sum of $7.00 ($2.00 initiation fee and $5.00 annual dues) to Dr. R. Caldwell, of San José, the Chairman of the Board of Censors.

An unusually full program has been presented, and from the titles of the papers and the names of the authors, it is quite certain that the scientific work of the meeting will be of a high order. There will be three sessions daily, except on the second evening, Wednesday, April 18th, when a reception will be given to the visitors, at the Hotel Vendome, by the Santa Clara County Medical Society. In another column we give the reductions in hotel and railroad rates that have been secured. There should be a large addition to the membership from Santa Clara and the adjacent counties. For some unexplained reason, the membership in this section of the State is much smaller than would be expected when it is remembered for how many years the Society has met in San Francisco, in easy reach of the Garden City. It is a long time since a meeting has been held in San José, but we trust that the results on this occasion will be so encouraging that a visit in the early future will be assured.

NOTES.

Rates and Fares.

The following reduction in transportation rates is available for visiting physicians and their families: The Southern Pacific Company will give the usual one and one-third fare round trip. No others have been mentioned. Passengers must take receipt of agent, and preserve same to be countersigned by the Secretary at the meeting, and upon presentation to ticket agent at San José a return ticket will be sold for one-third fare. Tickets can be purchased at any time before the meeting, and are good until 48 hours after adjournment. We understand that blank forms for railroad certificates will be sent out in a few days. The following reductions in hotel rates have been offered: Hotel Vendome, $2 and $2.50 a day, American plan; St. James Hotel, $2 a day, American plan.

Voluntary Papers.

The following are the titles of voluntary papers, with the names of their authors, that have so far been received: "Nocturnal Epilepsy," by F. W. D'Evelyn, San Francisco; "A Case of Intestinal Obstruction," by Kate I. Howard, San Francisco; "Puerperal Fever," by P. M. Lusson, San José; "Errors in Diagnosis due to Vagaries of the Colon," by C. M. Fenn, San Diego; "How to Cure the Morphine Habit in Forty-eight Hours," by G. W. Daywalt, San Francisco; "Antiseptic Cataphoresis in Treatment of Metritis and Endometritis," by W. A. Briggs, Sacramento; "Diagnosis and Treatment of Urethritis Posterior Chronica," by M. Krotozyner, San Francisco; "Purulent Ophthalmia, Legislation Against," by W. F. Southard, San Francisco; "Contribution to the Technique of Cataract Extraction," by J. D. Arnold, San Francisco; "Irregular Astigmatism," by E. S. Clark, San Francisco; "What Shall we Do for Cross-eyes in Children?" by K. Pischl, San Francisco; "Suggestions Regarding Treatment of Diseases of the Ears and Throat in Children," by M. C. O'Toole, San Francisco; "Lesions of the Lachrymal Passage and Nasal Duct," by H. I. Jones, San Francisco; "The Relation of Chronic Nasal Inflammation," by Thos. F. Rumbold, San Francisco; "Embolism After Fractures," by C. L. Bard, Ventura; "Total Extirpation of the Uterus," by H. Kreutzmann, San Francisco; "The Operative Treatment of Retro-Deviations of the Uterus," by F. W. Vowinckel, San Francisco; "The Present Status of Surgical Treatment of Laryngeal Tuberculosis," by J. D. Arnold, San Francisco; "The Ophthalmometer as an Instrument of Precision in the Diagnosis of Astigmatism," by H. Bert Ellis, Los Angeles.

The Discussions.

The following are the Standing Committees, with the names of the chairmen and of the members who will open the discussions in the various sections. Wherever obtainable, the title of the paper is also given: Clinical Medicine, Albert Abrams, San Francisco—"Clinical Observations on Pulmonary Atalectasis and Experimental Investigations on Congestion as a means of Diagnosis and Treatment;" M. Krotozyner, San Francisco. Surgery, E. H. Woolsey, Oakland—"Physiological and Pathological Effects of Electricity;" T. W. Huntington, Sacramento. Obstetrics, H. H. Hart, San Francisco—"Management of the Third Stage of Labor;" W. F. Cheney, San Francisco. Gynecology, W. H. Mays, San Francisco "The Curette, Its Indication and Dangers;" R. B. Cole, San Francisco. Diseases of Children, H. M. Sherman, San Francisco—"The Sources of Contagion of those Forms of Tuberculosis usually Seen in

Children, with Cases." Ophthalmology and Otology, W. D. Babcock, Los Angeles—"Tansley's Cut to Prevent Mastoid Trouble;" K. Pischl, San Francisco. Laryngology and Rhinology, A. Barkan, San Francisco—"Therapeutic Progress in Rhinology and Laryngology in 1893;" M. C. O'Toole, San Francisco. Diseases of the Mind and Nervous System, W. S. Whitwell, San Francisco—"The Commitment and Discharge of the Insane;" Asa Clark, Stockton. Dermatology and Venereal Diseases, D. W. Montgomery, San Francisco—"Some Mishaps with Drugs;" G. J. Bucknall, San Francisco. State Medicine, M. M. Chipman, San José; C. A. Ruggles, Stockton. Medical Topography, W. J. G. Dawson, St. Helena; W. F. McNutt, San Francisco. Indigenous Botany, W. P. Gibbons, Alameda—"Some of the Poisonous Plants of the Pacific Coast;" H. M. Pond, St. Helena. Medical Jurisprudence, G. W. Davis, San Francisco; C. G. Kuhlman, San Francisco. Histology and Microscopy, J. R. Curnow, San José—"The Final Distribution of the Nerves of the Viscera, with Some Remarks on Histology in General;" W. A. Edwards, San Diego. Anatomy and Physiology, W. B. Lewitt, San Francisco; C. E. Farnum, San Francisco. Pathology, D. C. Barber, Los Angeles—"A Resumé of the Progress of Pathology the Past Year;" J. C. Spencer, San Francisco.

Dead Drunk.

Under this heading, an editorial appears in the *Journal of the American Medical Association*, which casts some severe strictures on police officers and ambulance surgeons, who have overlooked serious injuries in persons apparently intoxicated. This is an old, old story, and should be pretty well understood by this time. We have frequently adverted to the liability of mistake in the diagnosis of a case where symptoms of intoxication are present, and have, from time to time, cited numerous examples. When such a mistake does occur, it lies not so much with the police or ambulance surgeons as with the lack of systematic provision for the care of such cases. Every community should provide for the instruction of the police regarding these doubtful cases and should see that facilities are at hand for placing them under immediate medical observation. At times it is impossible for even the most skilled to determine between intoxication and some more serious trouble. McBurney and Stimson write as follows concerning this point: "These mistakes have always been made and are now being made everywhere, and by the most experienced, and they will doubtless continue to be made as long as our perceptions and our knowledge have their present limitations. The science and art of medicine have not yet made it possible to recognize a fracture of the skull that gives no symptoms, or rarely to discriminate between some of its symptoms and those of alcoholic intoxication." In the absence, then, of some systematic provisions for attending doubtful cases, it is unjust to censure the police or others who may have been unable to determine whether a given case is drunk or dying. A mistake of this kind, especially when made by laymen, is perhaps hardly deserving of such expressions as "stupidity," "careless disregard of life," "crime," etc.

Fraudulent Listerine.

The Lambert Pharmacal Company have furnished us with the following information relative to the demonstration of the practice of substitution that apparently prevails to a very general extent in Chicago. Having learned that imitations of listerine were being very generally sold in that city the company sent an employe to 500 drug stores, at which small purchases of listerine were made. Four hundred and seventy-nine samples thus secured were taken to St. Louis and there examined, with the following result: Two hundred and fifty-one were genuine listerine; 204 contained no listerine whatever; 24 were listerine diluted with water or glycerine. The fraudulent listerine varied in color, odor, and taste, many specimens containing free oils and undissolved boracic acid, whilst others were fairly good imitations of listerine in both odor and taste, but lacking in antiseptic value. Later in the year the company sent a second representative to call upon the 204 pharmacists who had previously supplied fraudulent listerine, and to purchase from each, another quantity. On this occasion 161 gave a fraudulent imitation, containing no listerine whatever; 23 gave genuine listerine, and 20 samples were broken in transit. The St. Louis firm has brought an action against two of the most prominent firms in Chicago, and in one case, that of the Auditorium pharmacy, judgment has been entered in favor of the manufacturers. This evil of substitution is not confined to Chicago, nor to listerine; it prevails to a large extent throughout the country. It affects every preparation proprietary or otherwise that sells at a fair figure, by reason of its intrinsic excellence, or of the demand for it. The Lambert Pharmacal Company, while undoubtedly looking after their own interests, have at the same time done the profession a material service. Over 50 of the fraudulent pharmacists have signed an agreement to cease from substituting in relation to this article; and of the remainder, those who do not do likewise will be either prosecuted or their names will be made public. We believe the latter would be quite sufficient, and if this list were published in the Chicago medical journals it would prove a most wholesome object lesson.

A Standard for Tincture of Nuc Vomica.

The introduction of the new pharmacopeia has virtually decided a case that has for over two years been dragging its way through the New Jersey courts. According to the *Bulletin of Pharmacy*, there is a statute in New Jersey that says that any preparation sold under or by a name recognized in the U. S. Pharmacopeia shall be deemed to be adulterated if "it differs from the standard of strength, quality or purity laid down therein." Proceeding under this statute, the State Dairy Commissioner of New Jersey caused the arrest of two druggists on the ground of having sold a quantity of tincture of nux vomica that was adulterated. The pharmacopeal standard (of 1880) for this tincture, was the demonstration of two per cent. dry extractive matter. The tinctures in question had been prepared from the "normal liquid" of nux vomica of Parke, Davis & Co., and contained only 0.712 per cent. of dry extractive, hence the charge of adulteration. No attempt was made to show the presence or absence of the alkaloids upon which the activity of the preparation alone depended. Parke, Davis & Co. had adopted as their standard for this preparation a total alkaloid strength of 0.3. In support of their position, for the manufacturers paid the expenses of the defense, Professors Remington, Hare, Rusby, Ryan, Marshall, Dr. Eccles and the late Prof. Bedford unanimously testified that the quantity of dry extractive matter was absolutely worthless as a means of determining the strength of the tincture and that the proportions of the active alkaloids, strychnine and brucine, could alone decide this fact. It was also shown that the addition of a little glucose to an inferior tincture would enable it to conform to the U. S. standard. Judge Reed, before whom the cases were tried, decided in the first case that, while there was no dispute as to the medicinal value of the preparations of the real defendants, still, under the law, the tincture must be regarded as being adulterated. This was in the first of the two cases, the second still remaining undecided. The new pharmacopeia that went into effect on January 1, 1894, and which, therefore becomes a part of the laws of New Jersey, has virtually decided the cases. The standard for tincture of nux vomica of the pharmacopeia of 1880 has been abandoned, and one specifying a total alkaloidal strength of 0.3 has been adopted. As this is precisely the standard that had been adopted by Parke, Davis & Co., it may be regarded as a vindication of the manufacturers, whose test was practically, as well as scientifically, far ahead of the old pharmacopeia.

The Disabilities of the Late Acting Assistant Surgeons.

During the late war, and quite frequently since then, civilian physicians were employed as medical officers, serving in the regular army and under army regulations, in every respect on a parity with the commissioned medical staff. They performed the same duties, were allowed fuel, rations, quarters, transportation, and traveling expenses: They ranked as "first lieutenants" and were in all respects subject to military discipline. They have also been granted pensions under the laws governing payments to those injured or disabled by disease, when in the service of the government. It would therefore seem that they were on the same footing as other officers. It appears, however, that they are ineligible for admission to the military organizations known as the Loyal Legion and the Grand Army of the Republic. The former is limited strictly to those who have held commissions in the army, and, as the assistant surgeons were employed under contract, they are not regarded as commissioned officers within the rule of this order. To remove these disadvantages, the following bill has been introduced in the Senate and has been referred to the proper committee: "A Bill to remove certain disabilities of the late acting assistant surgeons. Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled: That private physicians who were employed as medical officers in the armies of the United States for a period of not less than three months, in accordance with paragraph 1268 of the Revised Regulations United States Army, 1861, and paragraphs 1304 and 71, Appendix B, Revised Regulations, 1863, and who were known officially as Acting Assistant Surgeons of the United States Army, and whose services were honorably terminated, shall be commissioned by the President of the United States as Acting Assistant Surgeons of the United States Army; and the date of employment as acting assistant surgeons to be the date of commission and muster into service, and the date of the honorable termination of service as acting assistant surgeon to be the date of discharge or muster out of service; *provided*, that no pay or allowance shall be made to any such acting assistant surgeon by virtue of this act; and this act shall not affect the rank, pay, or emoluments of commissioned medical officers of the United States Army." There is no question as to the services rendered by these men, or that they did not encounter the same dangers and exposures as regularly commissioned medical officers. Their list of killed and wounded, whether with the army during the civil war, or when serving on the frontier in the numerous Indian wars, is a long one, and it cannot be denied that they have earned the titles they now ask may be conceded them. As no expense is involved and as no change in the status of present or of future medical officers has been proposed, the request will probably be granted, The Association of Acting Assistant Surgeons which is pushing this matter, requests that any of our readers who have been acting assistant surgeons, and who are in sympathy with this movement, will communicate promptly with members of Congress and others, who are in a position to give material assistance.

AMERICAN MEDICAL ASSOCIATION.

Membership in the American Medical Association.—"This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues and subscription for the *Journal*. Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly *Journal* of the Association will be forwarded regularly."

Application Blanks for Membership.—On advertising page xxvii we print a convenient form of application blank that is being circulated by the Association *Journal*, Any physician desirous of joining the Association can cut out this blank, and, having properly filled it, can mail same with his subscription to the Treasurer. As many physicians seem to be waiting for these blanks before joining the Association, it is pertinent to remark that the blank is not a necessity but merely a convenience. The essential is a certificate signed by the President and Secretary of a State or local Medical Society, and this, accompanied by $5, will be duly honored by the Treasurer. Meanwhile our readers will find each month the regular application form in our advertising columns, and we shall be at all times ready to afford any information in these matters.

Place of Meeting.—The Committee of Arrangements has secured Odd Fellows' Hsll, corner Market and Seventh streets, as the place of meeting for the general sessions and the sections. This building furnishes one large hall with a seating capacity of 1,500, and twelve halls that can accommodate from 500 to 100 persons. There are also committee rooms in the building. This enables all the Association work to be carried on under the same roof, a very desirable feature that has not always been possible in other cities. It permits members to be present at different section meetings on the same day with the least possible loss of time, and by this concentration will tend to prevent stragglers. The acoustic properties of the main hall are good, and there is a large gallery for the accommodation of visitors.

Headquarters.—The headquarters of the Association will be at the Palace Hotel, corner Market and New Montgomery streets. It is, therefore, on the same street and just four blocks from the place of meeting. It should be mentioned that the whole of the Market-street system of cable cars traverses these four blocks—the Hayes, Castro, Valencia, and McAllister-street lines coming into Market street at Odd Fellows' Hall. This provides a car each way every few seconds, a service that is certainly not surpassed in any American city. The Registration Bureau, Association Post-office, etc., will be in Marble Hall, close to the hotel vestibule, and committees will meet in Parlor A on the first floor

One of the many features of the Palace is its central covered court, which will make it pleasant for the ladies when going to or coming from the different entertainments.

Hotel Rates.—The following hotels, centrally situated and convenient to the place of meeting, have quoted special rates, for members and their families, which will apply during the entire stay of the guests, who should, upon registering, signify that they are in attendance upon the meeting of the Association. The rates quoted are for one person, the variation depending upon the size, situation, and appurtenances of the rooms, as single, *en suite*, with private bath, etc.; special arrangements will be made for families, or parties, on timely notice. Some of the hotels entertain upon the American plan (room and board) only, some upon the European plan (room without board) only, and some upon either plan.

Palace Hotel (headquarters)	American plan, $3.50 to $5.50 a day. European plan, $1.50 to $3.50 a day.
Grand Hotel	Connected with the Palace by a glass enclosed bridge, across New Montgomery street, European plan only, $1 to $2 a day.
Baldwin Hotel	American plan, $3.50 to $5 a day. European plan, $1 to $3 a day.
California Hotel	American plan, $3.50 and up a day. European plan, $1.50 and up a day.
Lick House	American plan, $2.50 and up a day. European plan, $1 and up a day.
Russ House	American plan, $2.00 to $3.50 a day. European plan, 50c to $2 a day.
Occidental Hotel	American plan only, $2.50 and up a day.
Hotel Pleasanton	American plan only, $2.50 to $5 a day.

Postoffice.—Station K is located in the Palace Hotel, on the office floor adjacent to the Registration room, where members can receive all mail matter by having it so addressed.

Entertainments.—It is as yet too early to publish the various entertainments that have been decided upon. It is, however, known that Cooper Medical College will tender the Association a reception on one evening at the College. The Medical Department of the University will also give a reception at the Hopkins Mansion on Nob Hill, this being now, through the munificence of Mr. Searles, the property of the University. The San Francisco County Medical Society will also give an entertainment, either in the form of an excursion or of an evening reception. It is probable that one evening will be devoted to the Mid-winter Fair. Finally, there will be an entertainment on an elaborate scale given in the name of the whole State. This, with a number of private receptions of which we already have heard rumors, will fully occupy the time of the visitors.

Ladies' Committee of Arrangements.—The following ladies have been appointed as an executive committee, with power to add to their number, to coöperate with the Committee of Arrangements and to have special charge of the duty of entertaining the families of members who will attend the meeting of the American Medical Association: Mrs. R. H. Plummer, Mrs. W. W. Kerr, Mrs. W. R. Cluness, Mrs. W. S. Thorne, Mrs. H. Bert. Ellis, Mrs. R. A. McLean, Mrs. J. Rosenstirn, Mrs. H. Gibbons, Jr., Mrs. J. H. Parkinson, Mrs. R. L. Rigdon.

Finances.—DR. H. GIBBONS, JR., Chairman of the Sub-Committee on Finance, has issued a stirring appeal to the profession throughout the state, urging the necessity of liberal subscriptions toward defraying the expenses of entertaining the American Medical Association. It has been decided to confine contributions exclusively to the profession and not to appeal for outside assistance. In view of this fact, the various local societies have been urged to open subscriptions and in every way endeavor to afford all an opportunity to contribute. The San Francisco County Society has under consideration a very liberal appropriation, and a similar movement will soon be made in the State Society. As the time is growing short, Dr. Gibbons requests that immediate steps be taken, so that the Committee can ascertain how much money is forthcoming.

Railroad Rates.—The exceedingly disturbed condition of railroad rates on the various western roads has delayed us in announcing the reductions that the Committee of Arrangements had succeeded in obtaining. Within the past three weeks a rate war affecting all roads west of Chicago has still further tended to demoralize traffic. This has now terminated, and it is unlikely that another will occur between now and the meeting of the Association. In the event of another disturbance members would of course have the benefit of prevailing rates. It must, however, be remembered, as we have already indicated, that these very low rates are for continuous-trip tickets, and that when the desired route has been selected, a material saving may be effected by purchasing a round-trip ticket, to which attaches the fullest stop-over privileges. The following correspondence between the Southern Pacific Company and the Chairman of the Committee of Arrangements will explain the present status of affairs:

SAN FRANCISCO, February 12, 1894.

DR. R. H. PLUMMER, *Chairman Committee of Arrangements, A. M. A., San Francisco. Cal.*—DEAR SIR: Referring at the first practicable moment to your letter of the 4th inst., which you handed us in person, we beg to here repeat what we said to you at the time, to-wit: that certain of the roads connecting with us, known as Transcontinental Association roads, have announced a continuance until June 30th next of the sale of special rate tickets for San Francisco and return, on account of the California Midwinter International Exposition; and that it had been agreed to make such tickets good returning, until July 15th next. The rates thus continued are as follows: $65.50 from Missouri river points, being Sioux City, Council Bluffs, Omaha, Pacific Junction, St. Joseph, Atchison, Leavenworth, and Kansas City; $77.50 from St. Louis, Cairo, Memphis, and New Orleans. As on this occasion the passenger movement is from the east to the west, it is but proper that the question of rates should be taken up with officials of eastern roads. We suggest, therefore, that you correspond first with those who have charge of the passenger traffic of the so-called Transcontinental Association roads. The rates mentioned to you exceed the one-way, thirty-day rates, as follows: That from the Missouri river, by $5.50; that from St. Louis, Cairo, Memphis, and New Orleans, by $10.00; and that from Chicago ($85.50), by $13.00. We deem it but proper to here mention that if our Shasta route, between San Francisco and Portland, is passed over on either going or returning trip from Missouri river, St. Louis or Chicago, the rate will be $15.00 greater. T. H. GOODMAN,

Gen. Pass. Agent Southern Pacific Co.

SAN FRANCISCO, March 16, 1894.

DR. R. H. PLUMMER, *Chairman Committee Arrangements, A. M. A., 652 Mission St., San Francisco.*—DEAR SIR: This morning's mail brings us your yesterday's letter, handing for our perusal three letters from eastern railway officials. Having read the letters you sent, we return them herein, and beg to emphasize our previous statements to you, in person and by letter, that the transcontinental roads had virtually done what you ask, namely, accorded a one-way rate. In other words, the rate for a thirty-day ticket from Missouri river points to San Francisco points is $60.00. Excursion, that is, round-trip, tickets, Missouri river points to San Francisco and return, are being sold to-day at a rate of $65.50. Such tickets require the going trip to be made within fifteen days from the date of sale, and the return trip within fifteen days after the day upon which the ticket is signed here, in presence of a railroad agent, but in no event later than July 15th next. We have told you that within the State of California we ignore this fifteen-day limit on both going and returning trips; in other words, that the holders of the tickets are at liberty to move at will within the State of California, within the life of the ticket, and that the fifteen-day limit returning is not enforced west of our terminals at Portland, Ogden and El Paso. You have asked our permission to state positively that these Midwinter Fair rates would be in force at the time attendants at your convention will want to move westward. We have replied that the traffic is west-bound traffic, and that we do not control the matter. You will doubtless, however, recollect our telling you that this rate would, in all probability, hold until after that period. We gave you our reason for that statement, namely, that one of the roads had announced that it would continue the sales up to June 30th. We appreciate your desire for an authoritative statement in this regard. As we cannot make it, we will write you that we feel you are quite safe in stating the fact that such rates have been announced, and that the sale would continue until that date. We beg to again call your attention to one point which is quite material in this matter. The transcontinental roads having virtually done what you asked, you should bring all the influence to bear that you can upon the roads east of the transcontinental roads. These roads are, for the most part, the ones forming the Western Passenger Association, the Central Traffic Association, and the Trunk Line Association. The Western Passenger Association roads lie between the Missouri river and Chicago and St. Louis. You should go to them for a rate similar to our Midwinter Fair rate. They tell you their rate will be $20.00, Chicago to Missouri river and back, and $12.00, St. Louis to Missouri river and back. As the single-trip rate, Chicago to Missouri river, is $12.50, and from St. Louis $7.50. You will see that their rates are not reduced nearly as much as the transcontinental road rates. Can you not, through some of your profession at Chicago, approach the general passenger agents of the lines leading from Chicago, whose names we have given you? We think they will appreciate the importance of the occasion. One of our assistants has in hand the matter of reduced rates locally, and you will be shortly advised. Respectfully yours, T. H. GOODMAN,

Gen. Pass. Agent Southern Pacific Co.

From the above it will be seen that these are practically one-fare rates, and are, therefore, more liberal than are usually obtainable. Under the conditions upon which these tickets are sold, about six weeks will be available for visitors in this State. The Southern Pacific Company states that it will ignore this limitation within its territory. It therefore remains for purchasers to insure the acceptance by eastern connections of tickets upon which the holders have already traveled within the State of California.

Midwinter Fair Rates Positively Assured.—Since the foregoing was placed in type a meeting of the railroads forming the Transcontinental Association has been held, and an agreement reached extending the sale of tickets under what are known as "Midwinter Fair excursion rates," and which are referred to as such in Mr. Goodman's letters, until June 30th. We are in receipt of the following telegraphic advice:

> OCCIDENTAL MEDICAL TIMES, *Sacramento*, *Cal.*—Special rate $65.50, San Francisco and return, on account Midwinter Fair, will be continued till June 30th, from Missouri river points, Sioux City to Kansas City, inclusive.
>
> T. H. GOODMAN, Gen. Pass. Agt. S. P. Co.

This finally disposes of the vexed question of reduced rates, which has been giving the Committee of Arrangements no little anxiety. Should lower rates be in force, visitors will have the benefit of them, but this, which is virtually a one-fare rate, is now assured.

Itinerary of Excursions, with Cost of Same.—The following itinerary is published for the guidance of eastern visitors. It will be found to cover all points of interest in the State. We shall be pleased to furnish additional information or to answer inquiries on these points:

Mount Hamilton, Santa Cruz, and Monterey:

Leave San Francisco	Monday,	8:15 a. m.
Arrive Palo Alto	Monday,	9:36 a. m.

Visit Leland Stanford, Jr., University.

Leave Palo Alto	Monday,	12:03 p. m.
Arrive San José	Monday,	12:41 p. m.

Three hours in San José.

Leave San José	Monday,	3:48 p. m.
Arrive Del Monte	Monday,	6:15 p. m.

Stay at Del Monte can be prolonged indefinitely, but at least two days should be taken in which to see the objects of interest in the neighborhood. On the day following arrival, we would suggest that the famous seventeen mile drive be taken. This leads through Pacific Grove, round Cypress Point, along Pebble Beach, and back to the hotel, and is acknowledged to be one of the finest drives of its length in the country. On Wednesday, the old Mission Churches in the neighborhood and other objects of interest should be visited, and time can be taken for a dip in the surf.

Leave Del Monte	Friday,	6:53 a. m.
Arrive Pajaro	Friday,	7:38 a. m.
Leave Pajaro	Friday,	7:50 a. m.
Arrive Santa Cruz	Friday,	9:15 a. m.

On Friday morning we would suggest a drive along the beach at Santa Cruz, and in the afternoon a visit could be made to the Big Tree Grove. The drive up the cañon is much more interesting than the same trip by rail, and there is ample time to visit the big trees and return before dark.

Leave Santa Cruz (via Narrow Gauge)	Saturday,	8:00 a. m.
Arrive San José (via Narrow Gauge)	Saturday,	9:50 a. m.

Visitors to the Lick Observatory are allowed to use the instruments on *Saturday night only*, and the trip to Monterey and Santa Cruz should be arranged so as to arrive at San José on the return Saturday morning. This could be done by leaving San Francisco a day or two later than quoted above, but in order to examine the instruments at the Observatory, the trip there would have to be made Saturday afternoon on following schedule:

Leave San José (by stage)	Saturday, about	12:30 p. m.
Arrive Smith Creek Hotel	Saturday, about	5:00 p. m.

Dinner at Smith Creek Hotel.

Leave Smith Creek Hotel	Saturday, about	6:00 p. m.
Arrive Observatory	Saturday, about	6:45 p. m.
Leave Observatory	Saturday, about	9:30 p. m.

Return can be made to San José the same night, arriving there at 1:00 a. m. Sunday morning; but as this makes a rather tedious trip, we would suggest that a stay be made over night at Smith Creek Hotel, taking the road down the mountain in the early morning. If the morning happens to be clear, the ride is a very exhilarating one.

Leave San José..........................Sunday, 11:40 a. m.
Arrive San Francisco....................Sunday, 1:45 p. m.
Or leave San José.......................Monday, 8:00 a. m.
Arrive San Francisco....................Monday, 9:47 a. m.

Holders of excursion tickets to San Francisco and return, sold per account Midwinter Fair, either from points on the line of the Southern Pacific Company or from eastern points, can purchase an excursion ticket, covering the trip to Monterey and return, via Santa Cruz, for $4.90. Such a ticket bears the same limit as the original excursion ticket held by the passenger; but in no case more than thirty days from the date of sale, but allows stopovers at any point within that time. The trip from San José to the Lick Observatory and return is $5.00. The hotel charges at Monterey, Santa Cruz, and Smith Creek, will naturally vary with the accommodations, ranging from $3.00 a day upward.

Big Trees and the Yosemite:

Leave San Francisco.....................Monday, 4:30 p. m.
Arrive Berenda..........................Monday, 10:39 p. m.
Leave Berenda......................Tuesday, about 5:45 a. m.
Arrive Raymond..........................Tuesday, 7:05 a. m.

During the Yosemite season, a through Pullman sleeper is run between San Francisco and Raymond, without change.

Leave Raymond (by stage)................Tuesday, 8:00 a. m.
Arrive Wawona (by stage)................Tuesday, 6:00 p. m.
Stay over night at Wawona.
Leave Wawona........................Wednesday, 6:00 a. m.
Arrive Yosemite.....................Wednesday, Noon.

It is hardly possible to see the wonders of Yosemite inside, at least, three or four days, and the stay can be profitably prolonged to a couple of weeks.

Leave Yosemite (by stage)...............Monday, 1:00 p. m.
Arrive Wawona (by stage)................Monday, 6:00 p. m.
Stay over night at Wawona.
Leave Wawona............................Tuesday, 7:00 a. m.

Side trip is made from Wawona to the Mariposa Big Trees, staying long enough to get a good view of the latter.

Arrive Raymond..............................6:00 p. m.
Leave Raymond (by rail).....................7:00 p. m.
Arrive San Francisco........................5:45 p. m.

The round-trip rate from San Francisco to Yosemite and return, including Pullman fare, is $50.00. Cost of a double berth in sleeper between San Francisco and Raymond in each direction is $1.50. Holders of excursion tickets from the East to Los Angeles and return can purchase, at Berenda, a ticket to the Yosemite Valley and return for $45.00. Those holding excursion tickets to San Francisco and return can use them as far as Lathrop, and at that point purchase a ticket to the Valley and return for $47.00. The cost of accommodations in the Valley ranges from $3.00 a day up. The services of a guide can be secured at rate of about $5.00 a day.

Lake Tahoe and Return:

Leave San Francisco.....................Monday, 6:00 p. m.
Arrive Truckee..........................Tuesday, 6:40 a. m.
Leave Truckee (by stage)................Tuesday, 8:00 a. m.
Arrive Tahoe City.......................Tuesday, 10:30 a. m.

There are several resorts at Lake Tahoe, the principal one being the Tallac House. The rates at those resorts range from $2.50 a day upward. There are so many points of interest at the Lake, and one's time can be so pleasantly spent, that the stay can be indefinitely prolonged. The return trip can be made direct through Truckee, leaving Lake Tahoe in the evening and arriving at San Francisco the next morning, or the return can be made through Carson and Reno. The latter trip will give an opportunity of inspecting the famous mines at Virginia City, schedule being about as follows:

Leave Tahoe City	Monday,	11:30 a. m.
Leave Glenbrook	Monday,	1:00 p. m.
Arrive Carson	Monday, about	3:00 p. m.

It is necessary to remain here about 2½ hours, which will give time to visit the Penitentiary, in the quarries of which are found the mammoth footprints of prehistoric man, which will prove of interest to those of a scientific turn of mind.

Leave Carson	Monday,	5:10 p. m.
Arrive Virginia City	Monday,	7:00 p. m.
Tuesday morning at Virginia City.		
Leave Virginia	Tuesday,	5:20 p. m.
Arrive Reno	Tuesday,	8:05 p. m.
Leave Reno	Tuesday,	8:25 p. m.
Arrive San Francisco	Wednesday,	9:45 a. m.

Excursion tickets are on sale at San Francisco to Lake Tahoe and return, both ways via Truckee, at $16.00; going via Truckee, returning via Reno, $20.00. Tickets are also on sale, including board at the hotels at rate of about $2.50 a day.

Sacramento.—This city, the Capital of the State, in addition to the State Capitol, with its picturesque Park, and the E. B. Crocker Art Gallery, is the location of "Sutter's Fort," now being restored by the State. This fort, built by General Sutter in 1839, is interesting, as being the first American settlement in California, and for many years the haven for emigrant trains that crossed the plains. Sacramento is distant from San Francisco 98 miles, and can be seen when going to or returning from Lake Tahoe and the Sierras, as follows:

Leave San Francisco	7:00 a. m.
Arrive Sacramento	11:15 a. m.
Leave Sacramento	10:00 p. m.
Arrive Truckee	6.40 a. m.
Or leave Truckee	7:00 p. m., or 10:45 p. m.
Arrive Sacramento	2:40 a. m., or 5:45 a. m.
Leave Sacramento	3:00 p. m.
Arrive San Francisco	7:45 p. m.

To Lake County Resorts and Return.—There are numerous springs and summer resorts located in Lake county, reached through Calistoga. The principal attraction in that territory. however, is the Geysers, located in Sonoma county. The trip can be made as follows:

Leave San Francisco	Monday,	7:30 a. m.
Arrive Calistoga	Monday,	10:50 a. m.
Leave Calistoga	Monday,	11:30 a. m.
Arrive Geysers	Monday,	5:30 p. m.
Returning, leave Geysers	Tuesday,	8:00 a. m.
Arrive Calistoga	Tuesday,	1.30 p. m.
Leave Calistoga	Tuesday,	3:05 p. m.
Arrive San Francisco	Tuesday,	6:15 p. m.

The round-trip rate from San Francisco is $8.50. The trip can be made to the Geysers, going via Calistoga and returning via Cloverdale, round-trip rate being $11.00.

To Southern California:

Leave San Francisco	Monday,	5:00 p. m.
Arrive Fresno	Tuesday,	1:10 a. m.

Remain in sleeper until morning, and spend Tuesday at Fresno, inspecting the vineyards in the neighborhood, some of the largest in the State being located at that point.

Leave Fresno	Tuesday,	5:50 p. m.
Arrive Bakersfield	Tuesday,	10:05 p. m.

The system of irrigating is carried on to a large extent at Bakersfield, and this place affords an excellent opportunity of studying the methods in vogue in California. The Kern County Land Company conduct the system on an immense scale, the headquarters being at Bakersfield. A day can be very profitably spent in this manner.

Leave Bakersfield	Wednesday,	10:20 p. m.
Arrive Los Angeles	Thursday,	7:30 a. m.

Thursday, Friday, and Saturday at Los Angeles. On one of these days make a trip to Santa Monica and Port Los Angeles, where is located one of the longest wharfs in America. The beach at Santa Monica is unrivalled for bathing facilities. The following is the itinerary:

Leave Los Angeles	9:15 a. m.
Arrive at Santa Monica	10:22 p. m.
Leave Santa Monica	3:30 p. m.
Arrive Los Angeles	4:35 p. m.

A day can be profitably spent in Pasadena, as follows:

Leave Los Angeles	9:00 a. m.
Arrive Pasadena	9:30 a. m.

Take a drive to Sierra Madre Villa, going through East San Gabriel, where is located an interesting old Mission church, and returning through the ranch of L. J. Rose, and Baldwin's Santa Anita ranch.

Leave Pasadena	6:05 p. m.
Arrive at Los Angeles	6:30 p. m.

We would suggest that Sunday be spent at Riverside, going there Saturday afternoon, as follows:

Leave Los Angeles (via Colton)	4:30 p. m.
Arrive Riverside	6:55 p. m.

Riverside bears about the same relation to the orange industry in California as Fresno does to the raisin. Magnolia Avenue is acknowledged to be one of the finest streets in the world. The avenue is lined with orange groves, and makes one of the prettiest drives in California. From Riverside the trip to San Diego can be made as follows:

Leave Riverside	Monday,	7:55 a. m.
Arrive Orange	Monday,	9.15 a. m.
Leave Orange	Monday,	9:23 a. m.
Arrive San Diego	Monday,	12:50 p. m.
Arrive Coronado	Monday,	1:30 p. m.

Tuesday and Wednesday at Coronado.

Leave Coronado	Thursday,	6:30 a. m.
Arrive San Diego	Thursday,	8:00 a. m.
Leave San Diego	Thursday,	8:40 a. m.
Arrive Los Angeles	Thursday,	1:15 p. m.

Before returning to the northern part of the State, Santa Barbara should be visited; and probably some of the party would like to continue the journey over the rail and stage route along the coast, there being no through line in that direction. The following is the itinerary:

Leave Los Angeles	Thursday, 2:00 p. m.
Arrive Santa Barbara	Thursday, 7:05 p. m.
Friday, Saturday, and Sunday at Santa Barbara.	
Leave Santa Barbara	Monday, 8:00 a. m.
Arrive Los Olivos	Monday, 4:30 p. m.
Stay over night at Los Olivos.	
Leave Los Olivos (via rail)	Tuesday, 7:40 a. m.
Arrive San Luis Obispo	Tuesday, 11:30 a. m.
Tuesday afternoon at San Luis Obispo.	
Leave San Luis Obispo	Wednesday, 7:00 a. m.
Arrive Santa Margarita (via stage)	Wednesday, 9:00 a. m.
Leave Santa Margarita (via rail)	Wednesday, 9:30 a. m.
Arrive San Francisco	Wednesday, 6:26 p. m.

If return is made from Santa Barbara via the San Joaquin Valley, the itinerary would be as follows:

Leave Santa Barbara	Monday, 9:06 a. m.
Arrive Saugus	Monday, 12:15 p. m.
Leave Saugus	Monday, 3:58 p. m.
Arrive San Francisco	Tuesday, 10:45 a. m.

Holders of Midwinter Fair excursion tickets can purchase a round-trip ticket to Los Angeles and return for $18.00. At Los Angeles, we have special excursion rates to all resorts in the neighborhood. If the passenger desires to return by way of Santa Barbara, the agent at Los Angeles will lift his ticket reading to San Francisco, and on payment of $5.00 furnish him a ticket reading from Los Angeles to Santa Barbara and Santa Margarita to San Francisco. Tickets will have to be got for the intervening rail and stage lines, the rate from Santa Barbara to Santa Margarita being $7.30. Persons returning over this route can make side trips to Monterey and Santa Cruz, stopping at San José, to make the Mount Hamilton trip, itinerary for which would be about as outlined.

Paso Robles.—One of the most famous sanitariums on the Pacific coast is located at Paso Robles, on the line of the Coast Division of the Southern Pacific Company. There is a magnificent hotel located here, and the facilities for various kinds of baths are unexcelled. Every physician visiting the Pacific coast should make a special point of visiting this resort. It can be done in connection with the Monterey and Santa Cruz trip, or in connection with the journey from Santa Margarita to San Francisco, along the Coast route. There is one through train a day, in each direction, between Paso Robles and San Francisco, as follows:

Leave San Francisco	8:15 a. m.
Arrive Paso Robles	4:19 p. m.
Returning, leave Paso Robles	10:12 a. m.
Arrive San Francisco	6:26 p. m.

Connection is made at Castroville with the morning train from Monterey, and at Pajaro with the morning train from Santa Cruz. It will be noted that the train from Santa Margarita leaves that point 9:30 a. m., arriving Paso Robles 10:12 a. m. A stop-over of a day or two may be made at this point, and the trip resumed to San Francisco. A special reduced rate will be made at this hotel to members of the American Medical Association.

Up the Sacramento Valley.—The trip up the Sacramento Valley is made at night, the train arriving at the scenic part of the road the following morning. A favorite resort on this route is the Tavern of Castle Crags, a modern caravansary, modeled on the lines of the old-time inn. This would be an excellent place to sojourn for a day or two, taking in the sights in the neighborhood of Mount Shasta.

Arrive Castle Crags	Tuesday,	8:56 a. m.
Leave Castle Crags	Thursday,	8:56 a. m.
Arrive Portland	Friday,	8:20 a. m.

Spend a day at Portland.

Leave Portland	Friday,	5:00 p. m.
Arrive Tacoma	Friday,	10:40 p. m.

The return trip is as follows:

Leave Tacoma	Monday,	11:00 a. m.
Arrive Portland	Monday,	5:40 p. m.
Leave Portland	Monday,	6:15 p. m.
Arrive San Francisco	Wednesday,	10:45 a. m.

To Alaska.—The pleasantest way to make the tour to Alaska is to go by rail to Puget Sound, and connect with the Alaska steamships at Tacoma. This varies the monotony of a long sea voyage, and the scenery along the Shasta route and around Puget Sound is such as to make the trip exceedingly pleasant. The Alaska steamers leave Tacoma 4:00 a. m., Seattle 9:00 a. m., and Victoria in the afternoon, of the following days: June 7, 12, 22, 27, July 8, 12, 22, 27, August 6, 11, 21, 26, September 10. Passengers intending to take the steamer at Tacoma should arrive there early enough to go on board the evening previous to the sailing, as steamers leave at 4:00 a. m. Excursion tickets from San Francisco to Alaska and return, including passage by rail to Puget Sound, are sold at rate of $140. Tickets from Seattle or Tacoma can be purchased for $100. The itinerary for the trip, San Francisco to Puget Sound, is as follows:

Leave San Francisco	Monday,	7:00 p. m.

San Francisco and North Pacific Railway—Excursion Rate.—DR. R. H. PLUMMER, the Chairman of the Committee of Arrangements, has received a letter from the General Passenger Agent of the S. F. & N. P. R. R. offering a substantial reduction in rates for the visitors, and also for those attending the meeting. He says: "Our road runs through Marin, Sonoma, and Mendocino counties. It is considered one of the most delightful and picturesque rides in California. There is no territory in the world of the same size containing a greater diversity of mineral springs, for here all the principal waters of Europe are duplicated. To afford members of the Convention an opportunity to enjoy the beautiful scenery of this section, as well as to realize its agricultural resources, we will name a rate of *one fare* for the *round trip* over any portion of our line. As many of the springs and resorts are off the main line, it will be well for members to make up parties, when we will arrange, not only for railroad transportation, but also for staging, hotel accommodation, etc., for any number of days and for any number of persons, and will furnish the exact figures before hand." This very liberal offer will well repay any of the visitors to accept, as the scenery in the coast counties through which the road passes is very fine.

Section of Diseases of Children.—The officers of this Section are desirous of having all physicians interested in this department, take part in the work of the Section at the coming meeting in San Francisco. The papers already promised guarantee a successful session. The coöperation of the physicians of the Pacific slope is particularly needed. All who wish to contribute are requested to send titles of proposed papers to one of the undersigned. W. S. Christopher, M.D., Chairman, 408 Center street, Chicago; F. S. Churchill, M.D., Secretary, 271 North Clark street, Chicago.

Section on Surgery and Anatomy.—It is proposed to devote a portion of the time of this Section to the systematic consideration of a few selected subjects, upon which papers, each not occupying more than ten minutes, will be read. It is hoped that speakers discussing these papers will confine their remarks to brief addresses of five minutes' length. The topics and papers to be so presented are as follows: I.—*Malignant Growths.*—"The Pathology of Malignant Growths," E. Laplace, Philadelphia. "A Critique of the Sporozoan Theory of Malignant Neoplasms from a Micro-technical Standpoint," A. P. Ohlmacher, Chicago. "Clinical Recognition of Malignancy in Tumors," C. A. Wheaton, St. Paul, Minn.; Henry W. Coe, Portland, Oregon. "The Necessity of Early Surgical Interference in Malignant Tumors," R. A. McLean, San Francisco. "The Value of Caustics in Malignant Growths," John Parmenter, Buffalo, New York. "The Radical Cure of Malignant Tumors by Operation," J. H. Wythe, Oakland, Cal. "The Value of Inoculations with Septic or Toxic Agents in the Treatment of Malignant Neoplasms," John A Wyeth, New York. II.—*Tubercular Disease of Joints.*—"Early Symptoms and Diagnosis of Tubercular Joint Disease," Emmet Rixford, San Francisco; A. B. Judson, New York. "Conservative Treatment of Tubercular Joints," R. H. Sayre, New York; Harry M. Sherman, San Francisco; James E. Thompson, Galveston, Texas. "Operative Treatment of Tubercular Joints," Robert W. Lovett, Boston, Mass. "Treatment of Tubercular Joints by Injections of Iodoform," N. Senn, Chicago. "Treatment of Tubercular Joints by Injections of Corrosive Sublimate," R. H. Plummer, San Francisco. III.—*Hernia.*—"The Causation and Prevention of Hernia," James T. Jelks, Hot Springs, Arkansas; C. M. Richter, San Francisco. "The Management of Reducible Hernia," Emory Lanphear, Kansas City, Mo.; C. M. Fenn, San Diego, Cal. "The Treatment of Irreducible Hernia," James B. Eagleson, Seattle, Washington. "The Treatment of Strangulated Hernia," Joseph Ransohoff, Cincinnati, Ohio. "The Radical Cure of Hernia," W. E. S. Davis, Birmingham, Ala.; H. O. Marcy, Boston. Mass. IV.—*Hemorrhoids, Fistula, and Fissure.* "The Pathology and Symptomatology of Hemorrhoids, Anal Fistula, and Anal Fissure," J. M. Matthews, Louisville, Ky.; David Powell, Marysville, Cal. "Treatment of Hemorrhoids," H. M. Bishop, Los Angeles, Cal.; Charles B. Kelsey, New York. "Treatment of Anal Fistula," J. McF. Gaston, Atlanta, Ga.; G. B. Somers, San Francisco. "Treatment of Anal Fissure," Thomas W. Huntington, Sacramento, Cal.; Lewis H. Adler, Jr., Philadelphia. V.—*Fractures.*—"Treatment of Fractures of the Lower End of the Humerus," Oscar H. Allis, Philadelphia. "Treatment of Fractures of the Lower End of the Radius," P. L. Conner, Cincinnati, Ohio; C. L. Bower, Philadelphia. "Treatment of Fractures of the Neck of the Femur," Bedford Brown, Alexandria, Va. "Treatment of Gunshot Fractures, George A. Goodfellow, Tucson, Arizona. "Treatment of Fractures of the Shaft of the Femur," Llewellyn Eliot, Washington, D. C. "Treatment of Open or Compound Fractures," H. H. Mudd, St. Louis, Mo.; John B. Hamilton, Chicago. VI.—*Obstruction to Urination in the Male.*—"Effects of Obstruction in Urination Upon the Bladder and Kidneys," J. William White, Philadelphia. "Diagnosis and Treatment of Enlargement of the Prostate Gland," Hunter McGuire, Richmond, Va.; Wm. T. Belfield, Chicago. "Symptoms and Treatment of Stone in the Bladder," Wm. T. Briggs, Nashville, Tenn. "Symptoms and Treatment of Tumors of the Bladder," John B. Deaver, Philadelphia; C. F. Buckley, San Francisco. "Treatment of Stricture of the Urethra," J. Rosenstirn, San Francisco. Members who have specimens or patients to exhibit bearing on these topics, or who wish to make remarks in the discussion of them, are cordially invited to be present during the meetings of the Section. The titles of other papers to be presented to the Section will be published when the program of the meeting of the Association is issued by the Committee of Arrangements.

JOHN B. ROBERTS, Chairman, 1627 Walnut street, Philadelphia.
LLOYD W. MCRAE, Secretary, Atlanta, Ga.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, February 23, 1894.

The President, F. L. ATKINSON, M.D., in the Chair.

New Member.—A. M. HENDERSON, M.D., was duly elected a member of the Society.

Ruptured Tubal Pregnancy.—Operation.—Recovery.—DR. W. A. BRIGGS reported a case in which he had operated for a ruptured tubal pregnancy. The patient had so far done very well. At 3:30 P.M. on the 11th of February, patient was suddenly attacked with violent pain in the abdomen, followed by symptoms of collapse. Her previous history had suggested the strong probability of pregnancy. On examination, Douglass' pouch was found to be filled with a resistant mass. It was decided to open the abdomen, and, on doing so, dark blood welled up when the peritoneum was incised. A rupture on the under surface of the left tube was discovered, and the tube was removed. The bleeding had taken place into the abdominal cavity and not into the folds of the broad ligament. The patient's condition after the operation was very much better than before. Previous to and during the operation about 16 ounces of normal saline solution had been given by intra-cellular injection, and a quart of the same fluid with 4 ounces of whisky *per rectum*. In the after-treatment of the case the only complications were a slight septic infection at the seat of one of the intra-cellular injections, and the very great difficulty experienced in procuring a movement of the bowels.

Three Cases of Appendicitis.—DR. T. W. HUNTINGTON reported three cases of removal of the appendix, all of which presented points of interest. The first case was that of a young man who had had two attacks. The third attack was short and mild; there was a tumor in the right iliac region. On opening the abdomen, there was found evidence of marked adhesions. The appendix was removed. It was not gangrenous and there was no foreign body. It was a dangerous organ and there was perfect justification in its removal. The second case entered the hospital after the first attack. Appendicitis was recognized, and an operation advised, but declined by the patient. On the fourth day it was evident that there was an abscess resulting from an explosion of the appendix. An operation was performed at 7 o'clock that evening. An exploded appendix and a large abscess cavity were found. The man did badly, and subsequently an exploration revealed a large abscess cavity near the bladder. To-day he has a well-established artificial anus. The case is a deplorable one, as all these complications could have been avoided had an early operation been done. The third case had entered the speaker's office two days ago, complaining of "belly ache." There was a perceptible tumor, with pain and tenderness. Patient had consulted Dr. Taggert, of Bakersfield, and had come to Sacramento for operation. On the following morning he operated through a one and one-half inch incision. Found the appendix and drew it up, tied it off, and sutured the wound, and the man is going on to make a good recovery. There was no foreign body or concretion found, but the distal end of the appendix was gangrenous. This last case is one of great interest, as it was a first attack, and the patient, in all probability, would have gone on to a partial, and perhaps complete, recovery. The operation was done with the idea of finding an appendix partly diseased, but the speaker had been astonished to find it in a gangrenous condition.

DR. G. L. SIMMONS inquired the cause of the gangrenous condition.

DR. HUNTINGTON: Dr. Morris has lately written an article on this subject, in which he says catarrhal appendicitis is septic appendicitis, and that means gangrenous appendicitis. We may have the origin of sepsis from an infinitesimal amount of fecal matter, or it may be due to germs.

Dr. Thos. Ross read a paper entitled "The Relations Existing between the Regular Profession of Medicine and the Public." [Published at p. 184.]

Dr. W. E. Briggs, in opening the discussion, said: I heartily agree with the views expressed by the author Keathly. We, as physicians, should drop all titles implying that we hold exclusive dogmas which we do not nor ever did hold. We should not apply to ourselves even the title of "regular," but call ourselves simply doctors or physicians. Those who hold exclusive dogmas, and wish to be known as 'pathists, have the right to be so called, but they have no right to apply approbrious epithets, such as "alopathic" and "old school" to those who practise medicine and not a 'pathy. In regard to consulting with 'pathic doctors, I believe it can never be done either with benefit to the public or to the better element in the profession. There can be no consultation between a physician, in the broad sense of the term, and a 'pathic doctor. It would be dishonest to take money from a patient for a so-called consultation with a man who holds views which are claimed to distinguish the 'pathists from physicians, as no common understanding could be arrived at. Were such a course to be pursued by us, it would lower that public respect in which the medical profession is held. Our aim should always be towards higher qualifications, and the making our position conspicuous in the future, as it has been in the past, by being the scientific and educated part of the profession.

Dr. W. A. Briggs: The question of consultation with irregular physicians is a very simple one. Medicine is a science, or rather a series of associated sciences. From a scientific standpoint, it is quite as absurd to speak of different schools of medicine as of different schools of chemistry. Confining ourselves to medicine in the narrow sense, we may say that so-called "schools" have been established by men who have promulgated conclusions without pursuing the laborious preliminary process of accumulating and sifting the facts. This is conspicuously true of *similia similibus curantur*, that general law of therapeutics announced by Hahnemann nearly a century ago, and so zealously defended by his disciples to this day. It had no scientific demonstration; it has had no scientific verification. It was conceived as a dogma; it has remained a dogma. So with the fundamental tenet of eclecticism, that mineral remedies have no rightful place in the materia medica. There can be no common ground between the scientific and the dogmatic physician; their mental attitudes, their mental processes, are radically different; the former, as Hippocrates declared more than two thousand years ago, studies and interprets nature; the latter taxes artifice and ingenuity to their utmost in the defence of preconceived opinions. The scientific physician can afford to ignore that "school" of physicians who proclaim the universality of the therapeutic law of *similia similibus curantur*, just as the scientific astronomer ignores that "school" of astronomers who declare "the sun do move." The parallel is not unjust to homeopathy, for in truth there is more evidence—the evidence of our senses—in favor of the latter conclusion than of the former. The scientific physician should decline professional association with dogmatic physicians of whatever "school," because, on the whole, such association would not benefit the patient, because it would confuse the public mind still more as to the landmarks between scientific and dogmatic medicine, and because it would degrade the profession itself by substituting purely mercenary for moral considerations.

Dr. F. B. Sutliff: I was pleased to see in The Medical Times the minority report of Dr. Didima, of New York. This report has the right ring to it. There are no consultations with homeopaths, or any other irregular class of men, for him. He cannot be enticed with a consultation fee, or any number of them, into taking a step which he thinks would be detrimental to the science of medicine. I believe the action taken by the New York State Society on this question some years ago was unwise, and such men as he can see it. He believes in practising medicine without regard to 'pathy or school, seeking only the welfare of his patient. It seems to me that all thoughtful men might easily follow him.

Dr. J. R. Laine: I am in accord with the main spirit of the paper. If, however, it had been read before a body of non-professional men, it would have given them to understand that we stood in a very bad light before the public.

I believe, on the contrary, that rational medicine stands well before the public eye, not only in this, but in foreign countries. Those admitted to the army and navy and the marine hospital service are all chosen from our ranks. The leading scientists of our generation call us brethren. The other branches of medicine—those with fanciful names and fantastic pretentions—are our equals before the law, with nothing in their way to advancement to medical and surgical learning. They avail themselves of the expedients of rational methods. They use homeopathy and eclecticism as catchwords and baits. The gudgeon caught are generally the well-to-do, filled to repletion with food and vanity, who must take their medicine as they do their devotions, in a very agreeable way. I am convinced that the public value and appreciate the well equipped, well balanced and intelligent physician. That homeopaths and eclectics get appointed on boards of health and to hospital service occasionally, cuts but little figure, but it improves them by insensibly leading them to broaden their methods, and opens the eyes of the more honest and enlightened to the absurdity of any law of cure. Our contention is not with them as men; it is against the monstrous doctrine of a general law for the cure of disease. We deny *in toto* its specious pretentions and disapprove its ethics. We regard the deflection from its tenets as wicked deception, and naturally object to the use of rational treatment, opposed to homeopathy, while at the same time professing under that name to practise its teachings. If they wish to be honest, let them call themselves "physicians" only, when, if in the matter of school preparation and ethical deportment they are our equals, the quarrel is done. But if they choose to masquerade under the heraldry of homeopathy or eclecticism, grasping at every thing outside of their law of cure to bolster them up to a position of dignity before the public, then we are bound to disapprove of such sham and hypocrisy. Otherwise, we are false to our convictions. The people are everywhere indifferent to our attitude when we merely stand on our dignity. Homeopathy is everywhere losing ground. General intelligence is as fatal to that as to any other dogma. We have, in my opinion, no choice but to pursue the even tenor of our way, rejecting all compromises tending to show that we begin to approve of methods and ethics which we have again and again found reason to condemn.

Dr. J. H. Parkinson said it was a mistake to say that the public asked us to consult with 'pathists and irregulars. This unreasonable demand was only preferred by a small and decreasing minority. According to the last edition of the Medical Register, there were in this State in active practice 1910 physicians, 267 eclectics and 354 homeopaths. It could be ascertained by investigation that even these figures did not fully represent the true state of affairs, but that an overwhelming majority of the people demanded *medicine* as opposed to the theory or practice of any so-called school. It was an insult to nine-tenths of the people to countenance such an obviously mendacious statement, yet it was one that the 'pathists were constantly advancing. It had always seemed to the speaker that a man who followed any 'pathy was either an honest, conscientious believer in that which we believed to be an absurdity, or else that he was a fraud professing to practise that which he did not employ and in which he did not believe. It was very evident that with the first class, and they were certainly in the minority, we could have no common ground for investigation or for treatment. The second class were impostors and charlatans, fradulently using a title as a means of financial gain. He asked if any honest physician could or would desire to meet these men. Regarding the agitation for a new and a more liberal code, the demand for any change had not been presented by the great body of the general practitioners, but by the specialists. The general practitioner did not desire to consult with irregulars. Apparently a large number of the specialists did hanker after some such unholy association. The conclusion seemed inevitable that this illicit longing was prompted by a commercial rather than by an ethical consideration. These were the same men who often advanced the proposition that there was no consultation between the practitioner in charge of the case and the consultant or specialist. These people were pirates in medical practice and their ethics should certainly be untramelled by any rules save those of temporary self-interest. The speaker believed that the days of sects in medicine or of schools or 'pathies were numbered. Their extinction was only a question of time, and that time would not be very long. There would always be quacks, just as there would be fools, to the end of time, but the progress of scientific medicine and the greatly increased demands of higher medical education would exterminate the 'pathies. On the other hand, the increasing knowledge of medical and of scientific subjects by the people would largely decrease the demand for unscientific methods.

Dr. H. H. Look said: The medical profession is still experimenting as to the use of drugs. The science will very likely never become exact. When we prescribe a certain remedy, it is done on our own experience or on the authority of others; and yet, how often does it fail to do what we expect of it? Homeopathy arose and grew a protest against the abuses of the past, when therapeusis was crowded with visionary cures. I doubt if we are intellectually brighter than our fathers, except that we have their experience on which to build. We do not make their mistakes, but often make others which our professional descendants will avoid. I do not think we can meet with homeopaths or eclectics on any common ground, so cannot consult with them. I have always tried to disabuse the public mind of the notion that we follow any 'pathy or cure other than rational medicine, and that we are any thing else than physicians.

Dr. C. B. Nichols: Regarding the part of the paper which refers to consultations with men who have a 'pathy, such a consultation is impossible; there is no middle ground that men who are not certain of their foundation can stand upon. A consultation with the man of 'pathies means that one or the other must surrender his advertised principles. In either case it is rank deception. I know there are men who claim to be regular physicians, if you please, who meet the irregulars in their offices and quietly *instruct* (I believe they call it) them in the treatment of some difficult case. Men who are so anxious to be popular with the friends of the irregular that they quietly call upon them with the attending irregulars and tell them what *they* would do in such a case. . Poor indeed, in honor, is the man who, for a paltry fee, will surrender his manhood.

Dr. G. L. Simmons: I fully endorse the general sentiments of the paper of the evening and think it important to endeavor to educate the public upon the subject of the relation of physicians to all kinds of "'pathies" and the various quack methods of the present day. The terms "old school" and "allopathists" have been applied to regularly educated medical men for so many years by homeopathists, motorpathists, eclectics, and cancer curers, that press and public evidently believe there is a class of physicians educated and acknowledged as allopathists. As a collective body our profession has never disproved this erroneous idea, and its general acceptance by the people does infinite harm to truth and rational medication. I can see nothing unprofessional in advertising facts in this connection, and I believe good would come to the public and our profession were the present habit of silence upon the points named abandoned.

Dr. C. E. Fowler: There is an old saying of "sowing the wind and reaping the whirlwind." If we could be transported back three hundred years and be spectators of the treatment of disease, we might sincerely hope and pray for a 'pathy that might arise and throw some light upon the dense ignorance then prevailing. Even not that long ago medicine was given in an irrational manner, and witches and sorcerers plied their unholy vocations with perhaps as many claims to scientific knowledge as their brethren of the lancet and scalpel. Knowledge, as we now apply the term to scientific medicine, was but in its infancy, and abuses arose which required many years to overcome. Perhaps Hahnemann, being a close observer of human nature, saw these abuses, and the founding of the so-called school of homeopathy was an attempt at the alleviation of the then existing condition of things. I believe that the founding of different schools of medicine in the past, had a good effect, inasmuch as it tended to a further research into the mysteries of nature and stimulated thought. That the necessity for the different schools of medicine no longer exists is apparent. Great advances in the lines of scientific knowledge have been made during the present century, and medicine has kept pace with the rest. There is no need for 'pathies to-day: Germany was the birthplace of Hahnemannism, but statistics tell us there are but 218 homeopathic physicians in Germany. For other countries the statistics are as follows; Austria, only 118 claim any connection with homeopathy, while but 44 practice it exclusively; Great Britain and Ireland, 256; Belgium, 41; France, 97; Russia, 71; Italy, 55; Spain, 131; Switzerland, 26; and on the entire continent of Europe there are but 1,022 practitioners of homeopathy, in a population of at least 300,000,000 people. In our own country they are holding their own, due undoubtedly to the cosmopolitan character of our people and the readiness with which all "fads" and innovations are embraced. It has reached its highest eminence, however, and will disappear before the advancing headlight of increasing knowledge.

MR. J. A. WOODSON, of the *Record-Union*, who had been invited to be present, was called upon. He said he was here as a listener only, and he had heard with interest and great profit. The peculiar manner in which the subject had been approached in the paper of the essayist, and by the speakers criticising it, placed him somewhat in the position of the man who declared that in opinion on a certain subject he stood facing south by north. Dr. Simmons, for instance, thinks that this is a matter calling legitimately for missionary work. Others believe that silence is the wiser policy, because the truth can be trusted to vindicate itself. But both are right, and he agreed with both; truth will vindicate itself, but truth always is worthy of the aid of missionary effort. This is, then, a question of policy—what will best serve before the public? For himself, while always nervous and impatient if reforms in which he enlists do not move rapidly forward, yet he must confess that in this case silence would be most potential, for the reason that agitation would afford the other side the better opportunity to use its weapons. There is tremendous power in the dignity and serenity of silence as contradistinguished from the clamor of vociferous protest. As to the press and its treatment of doctors in this cognominal matter, editors are placed in a most peculiar position. How are they to speak of physicians of the order here represented? Shall they simply say "physicians" or "healers," and thereby include all who so style themselves? If they are to distinguish between the orders, tell them how to do it. Are they not to say this is an allopath? Very well. Shall they say he is a regular? If so, what will the other fellow say to them? Will not his protest be worthy of respect when he objects to being distinguished as an "irregular?" No, gentlemen, the press does not side for or against you in this matter. It speaks of you in the only way given to it to distinguish you from others. The press does not create public opinion; such belief is fallacious. The press endeavors to discern the truth and to guide public thought aright by its exposition. But public opinion exists; it is as the all-pervading ether; it is a result over which no one agency has control. So, gentlemen, the press takes you as it finds you, leaving to schools the settlement of the question of your proper entitling.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, February 5, 1894.

The President, ALBERT ABRAMS, M.D., in the Chair.

New Members.—GEO. K. FRINK, M.D., CHAS. H. ROSENTHAL, M.D., WM. NORBERT SULLIVAN, M.D., and A. H. VOORHIES, M.D., were duly elected members of the Society.

DR. T. L. MAHONEY read a paper entitled "Chronic Indigestion." [To be published.]

DR. GEO. F. HANSON, in opening the discussion, called attention to the confusion of terms intended to apply to the condition in question, and dwelt at some length upon the pathology of chronic glandular gastritis. He then considered the etiology of chronic indigestion, as resulting from the acute and subacute forms of gastritis—from affections of the liver and spleen, with sluggishness of the portal circulation; heart affections, tuberculosis, through altered states of the blood, as chlorosis, scrofula, anemia; the acute exanthemata, typhoid, diabetes, uterine disease, gout, chronic affections of the kidneys, and most commonly from irritants, as improper food, spices, alcoholic drinks, tobacco juice, fluids taken too hot or too cold, carious teeth; intestinal entozoa, urea, and intestinal putrefactive products in constipation. The diagnosis and consequences of chronic indigestion were then considered, the latter with reference to the point dwelt upon by Dr. Mahoney, as to the effect of long continued indigestion in weakening the vital resistance of the tissues to extraneous pathological influences. Nothnagel, Ewald, and others were quoted to show that such weakened systems easily fall a prey to tuberculosis and to acute articular rheumatism in particular. The speaker then reviewed the treatment in detail, and mentioned a line of occupations to sustain his belief, which was no new one, that nearly every case that had not advanced to glandular destruction or atrophy could be improved by proper food, abundance of oxygen, and judicious exercise. Lavage, massage, electricity, baths, saline mineral waters, and drugs are all worthy adjuvants in selected cases. Thorough mastication of food and care of the teeth should be insisted upon in all cases. Of drugs, possibly the tonic laxatives, having a stimulant action upon the hepatic functions and a "toning" effect upon the muscular walls of the alimentary canal, prove more generally serviceable than any other class.

Dr. J. O. Hirschfelder said the author of the paper dwelt only on one of the numerous causes in chronic indigestion. In order to be clear it is necessary to know the part played by each portion of the digestive apparatus. The late Dr. Martinache had suggested that if people chewed their food till it was reduced to a liquid, the stomach would be relieved of a considerable amount of labor. Dr. Hirschfelder had tried the experiment and had found that from 100 to 150 movements of the jaw were required for each mouthful. This is chewing more than is required for digestion. It is necessary, merely, that the food should be ground up and mixed with saliva. In the stomach the juice should be in proper quantity and proper quality, and should come into contact with each particle of food. This intimate mixing depends on the activity of the gastric muscle. If mucus is present the particles of food are covered and are not reached by the digesting fluid. The partially digested food must pass out of the stomach readily and the intestine must properly complete the work. Thus there are many factors which may lead to indigestion; but to go into them all would require more time than was available.

Dr. A. W. Perry mentioned a cause of indigestion, insufficient mastication, whose ill effects he had learned from the laity how to relieve. In the stomach of those who chew insufficiently, there is apt to be produced an acetic fermentation. Several of his patients had found that this could be prevented by chewing gum after each meal. The Yankees eat lunch in a great hurry. At the Chicago Fair it was estimated that in many of the restaurants three and a half minutes was the average time taken for lunch. The Yankees, *i. e.*, the people of the northeastern part of the United States, have the habit of chewing gum, spruce gum, manufactured gum, etc. This wide spread habit is probably based on some good principle. Experience has taught them that they are troubled less with sour stomach if they chew gum after eating. This had proved of great value in his practice.

Dr. Washington Ayer said: Dyspepsia is one thing and chronic gastric catarrh another, and it should receive different treatment. Dr. Hanson told of some one being cured by eating sauerkraut. He had treated a gentleman for chronic gastric catarrh for a long time unsuccessfully, when he told him he had seen highly recommended, a new remedy, viz: to eat plenty of corned beef and cabbage, and put plenty of vinegar on it. The man tried it and returned in a week or two saying that he was perfectly cured.

Dr. L. C. Lane said a surgical aspect of the subject had been brought up which reminded him of reading in the works of Van Helmont that the stomach was the seat of twelve things, among them the soul. If the soul is not in the stomach of man it is certain that that organ is closely connected with the mind or fancy. A man came to him to get rid of a squirrel which had gotten into his stomach and distressed him sorely. After trying various measures, he suggested that the squirrel could be burned out, so he applied burning wax to the abdomen. The man bravely stood it, but returned in a couple of weeks with the story that the squirrel had not only come to life again, but that she had had a litter of young ones.

Dr. Hanson said that while he was in Chicago he had seen some of those three-minute lunches, referred to by Dr. Perry. The favorite quick lunch was a lump of ice-cream on a piece of apple pie washed down with ice-water.

Dr. Robert L. Jump read a paper on the "Persistence of the Müllerian Duct in the Male," and exhibited a specimen, in which the ducts persisted on both sides, each opening into a kidney cyst [published at p. 173].

Dr. C. N. Ellinwood detailed the surgical history of the case, saying that the man had been operated on by him for stone, by the suprapubic method, with perineal drainage and suture of the bladder wound. All went well for two days, when suddenly symptoms of severe sepsis occurred, and the patient died. The autopsy showed the suprapubic wound and the tissues about it free from infection. The peritoneum had not been injured in the operation. In the cellular tissue on each side of the prostate were found collections of fluid resembling thin pus. On examining the kidneys, the condition described in the paper was found.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE, AND THROAT SURGEONS.

Regular Meeting, March 1, 1894.

The President, A. Barkan, M.D., in the Chair.

Legislation for the Prevention of Ophthalmia Neonatorum.—The subject of legislative action having for its object the prevention of blindness caused by blennorrhea neonatorum, was discussed. It was resolved that the members of the Society, acting as a committee of the whole, request other specialists throughout the State to join them in bringing the matter before the committee on legislation of the State Medical Society, and in urging the necessity of having a law framed similar in character to that recommended by the section of ophthalmology of the American Medical Association, and already adopted by the Legislatures of several States.

Dr. A. Barkan presented a very interesting case of intra-laryngeal growth. The patient was a young man, aged 24 years, with no family history of hereditary disease. Two years ago he experienced the sensation as of some foreign body being lodged in the region of the larynx. It gradually became more troublesome, though no attention was given, as there was no pain. A piece of the growth was removed last April, in Tacoma, after which the trouble improved so much that patient thought it was cured. There was a recurrence last fall, but without pain or difficulty in respiration. Before this operation there had been occasional slight hemorrhage, but none since that time. The speaker saw the patient for the first time two months since. There was then a large growth on the left false vocal chord, red, but without ulceration or edema. The arytenoids appeared normal; the growth projected over the left vocal chord, and was sessile. After a local anesthesia the growth was partly removed by means of the laryngeal punch forceps; every three or four days small sections of the tumor were removed. The tumor was hard and of a fibrous nature; healing of the cut surface was rapid, and was hastened by suitable applications, such as nitrate of silver, Monsel's or Ligol's solution. The case [patient exhibited] showed on examination a uniform thickening and reddening of both ventricular bands and of the vocal chords. The mucous membrane covering the arytenoids was tumefied and reddened, exhibiting on either side a commencing ulceration. This had only manifested itself within three or four days. Dr. H. Gibbons, Jr., examined the lungs of the patient, but found nothing definite which would determine the nature of the growth. Dr. Emmet Rixford made a section of the growth, and demonstrated the specimen before the Society. The section was rich in connective tissue, and numbers of typical tubercles were present showing finely marked giant cells. As to treatment, the consensus of opinion was that nothing more could be accomplished in an operative way. Lactic acid was agreed to be the one local remedy indicated by the present condition of the patient.

Diffuse Interstitial Keratitis of an Unusual Character.—Dr. W. A. Martin exhibited a patient suffering from corneal trouble. The man was 40 years of age, by occupation a painter. He gives no history of tubercular or syphilitic trouble. Eyes were always sound until last Christmas, when he noticed a commencing haziness of vision in the left eye, which gradually grew worse, until he presented himself for treatment at the polyclinic four weeks later. On examination, the speaker found a diffuse keratitis that seemed confined to the superficial layer of the cornea, and an irregular mass of pus was lying in the anterior chamber. Patient was entirely free from pain and only complained of the interference with vision. The iris reacted well both to light and convergents, and there were no signs of active inflammation. Atropine was instilled and the patient given a simple borax-camphor lotion. He was seen a week later, and at the point where the pus was seen lying in the anterior chamber an ulcer was developing in the cornea, but the corneal surface was unbroken.

Two days later it had broken down, leaving a ragged ulcer. Atropine was discontinued and various remedies were used, but after six weeks' treatment the cornea showed no inclination to improve. At present he is using pyoktannin (1:1000). Separate foci of infiltration developed throughout the cornea so that there was now a well developed interstitial keratitis. The pupil still reacted to light.

Dr. W. F. Southard was in favor of using the galvano-cautery. He had met with uniform success with this means. He mentioned several cases, none, however, exactly parallel with the present one. He would have no hesitancy here in touching the ulcerated surface with the cautery point, and even the whole margin of the cornea where there was any tendency to ulceration.

Dr. G. H. Powers said that in such cases, where there was an indolent process, he had great confidence in jaquerity, not in continued treatment as advised by some in trachoma and pannus, but in instilling a weak infusion sufficient to set up a moderate reaction.

Dr. A. Barkan said that he regarded the eye as lost, or would rather say that the prognosis was exceedingly bad. He believed in the cautery, but did not anticipate that any benefit would result from its application in the present case. If this case had occurred in his own practice, he would have been tempted to make a large irodectomy in order to keep up a free communication between the anterior and posterior chamber, and avoid any chance of increased tension that might arise from the sluggish condition of the eye.

Dr. A. A. Drosel agreed with Dr. Barkan in not believing much would be accomplished in this case by the application of the cautery. He thought there must be some iritis present, judging from the general condition of the eye, although the cloudiness of the cornea precluded any positive opinion.

Dr. Martin, in replying, said: The man being a charity patient, single, and with no home accommodations, he would hesitate to use severer measures until others had failed. If the patient were in a hospital, where he could receive proper attention, it would be a simpler matter, and more heroic treatment might be used. He would venture on the use of the cautery, as all agreed that, at least, no harm could be done, while some benefit might be derived.

CALIFORNIA NORTHERN DISTRICT MEDICAL SOCIETY.

Semi-annual meeting held at Woodland, Tuesday, April 13, 1894.

MORNING SESSION.

The semi-annual meeting of the California Northern District Medical Society was held at the City Hall, Woodland, Tuesday, March 13, 1894. The meeting was called to order by the President, W. A. Briggs, of Sacramento.

Addresses of Welcome.—The Hon. J. O. Maxwell, Mayor of Woodland, on behalf of the city, first addressed the Society. He said: It is indeed a pleasant task assigned me to welcome to our quiet but thriving little city those of you who have assembled here to take part in this convention. While I may not be able to fully and adequately express myself upon the subject of your meeting I can assure you that your presence among us is very agreeable and that a hearty welcome awaits you all. I notice that some of you are strangers to our city, but under the guidance of our Committee of Arrangements I presume and hope you may soon become better acquainted with our people. It is true that in this little sylvan city, surrounded by vines and branches, we do not pretend to be a metropolis, but the name of Woodland stands to-day noted for its friendship and hospitality. On behalf of the citizens, I extend to one and all a hearty welcome to our city, and place its freedom at your disposal as long as you wish to remain with us.

Dr. E. K. Caldwell, of Blacks, on behalf of the Yolo County Medical Society, said: The duty has been assigned to me to extend to all present, and who may be present, a hearty and cordial welcome from the Yolo County Medical Society. We look upon it as a high compliment that you saw fit to meet among us on this occasion, and knowing as we do that you have spared no pains in arranging for your papers, we hope that when you leave us that you may feel that our expectations have been of a high degree and that you will realize these expectations have been met. The Committee of Arrangements of our local Society have arranged for a banquet to be given after the close of the session, and we request all who possibly can to remain. As actions signify more than words, we will endeavor by our actions to show that your presence among us on this occasion is highly appreciated.

DR. H. D. LAWHEAD, Chairman of the Committee of Arrangements, said: In keeping with that rational empiricism which is the high art of regular medicine, you voted at your annual meeting in Sacramento, six months ago, to favor Woodland and the Yolo County Medical Society with this, your semi-annual meeting. That the results of this experiment may confirm the judgment which granted us this esteemed consideration has been our constant anxiety. This is the first meeting of such character and importance ever held in Woodland; and when I recognize here those who represent the intelligence, strength, and progress of the profession in Northern and Central California, and recall what these worthy representatives have accomplished in the various departments of medicine and surgery, and reflect that just such enterprise procures us this meeting with its opportunities for our good, I am profoundly impressed by the significance of your presence. Your presence means much to our little city, whose honorable representative has bade you welcome. Your presence means much to the Yolo County Medical Society, whose heart seems willing to live but whose flesh is weak, though no vicious germs or malignant bacilli infest its vitals, it is anemic from voluntary inanition. It desires to catch your inspiration, take on your caloric and live nearer up to its duties as well as its privileges. Your presence means very much to every local physician in this section. This conference with you raises us out of our narrow individualities into higher altitudes, where the horizon broadens and reveals new possibilities for us and new benefits for our patrons. Your presence means much to organized society work, state and national, as well as local. You generate the energy which concentrates effort and enables all who will to enjoy fully those special privileges which can only come through well-organized and systematic coöperation; that you are preparing for us, and us for the State Medical Society and the American Medical Association, whose meetings come within the next few months. Here we are forcibly reminded of the importance and necessity of contributing to the healthful growth of this Society by a large addition to its membership to-day. Your part of the program shows the practical, scientific, and intellectual feast you have prepared for us; while on our part, we have endeavored to indicate our pleasure at your coming, and it is our earnest desire that every member may be able to remain throughout the entire session, and join us in a banquet to be given by the local Society, at Byrne's hotel, at 9 o'clock this evening.

THE PRESIDENT, DR. W. A. BRIGGS, of Sacramento, then read an address taking for his subject, "How Medical Societies may Best Promote the Welfare of the Medical Profession and of the General Public." [Published at p. 169.]

Diphtheria.—O. STANSBURY, of Chico, read a paper on this subject. He said it was not his purpose to note any new facts in connection with this disease, but only to call attention to some observations made from a practical standpoint. He then alluded to the pathogenic organisms which are now regarded as the cause of diphtheria, and that it had been demonstrated that one species was identified with the malignant variety. The present state of our knowledge rendered a diagnosis in the early stages often impossible except by bacteriological investigation, and this was beyond the reach of the general practitioner. The most dire results often followed this failure, and it was undoubtedly the safest plan in these cases to regard all as suspicious until the disease has been fully developed. The speaker then mentioned several cases occurring in one family, in which the difficulty of diagnosis in the early stages was very great. Prophylaxis was one of the most important duties of the medical attendant. No children should be allowed to attend school while this disease existed in a family. Such regulations were more easily carried out in the country than in a city, but they should be enforced as far as practicable. It was a fact that while the other infectious diseases had decreased, this disease was on the increase, and the cause, no doubt, was the difficulty experienced in quarantining those who had been exposed or who had had the disease in a light form. He then entered at some length into the subject of treatment, stating that there was no specific, but that success depended more upon the careful and unremitting administration of the remedies selected in the first stages of this disease, particularly during the first forty-eight hours. This was the critical period in every case, and close attention would then effect much more than at a later stage. [To be published.]

Dr. L. Welges, of Woodland, in opening the discussion, said: In regard to the etiology of this disease, it is taken for granted among our profession that the bacillus of Loeffler must be credited with the primary cause of the malignant form of diphtheria. He distinguishes two different microörganisms, and with each a benign and a malignant form. The streptococcus only is found in the former, which, almost without exception, will terminate in recovery, if treated in due time. This favorable termination in some epidemics undoubtedly causes too often the claim for so-called specifics; but in reality these prove only mere delusions when tested in epidemics of the true malignant forms, and characterized by the bacillus of Loeffler. There the death rate, in spite of the best treatment known, as sublimate, turpentine, carbolic acid, chlorate of potassium, chloride of iron, etc., is about 40 per cent. In order not to be misunderstood regarding the death rate, we must give due allowance to the almost invariably favorable results in the benignant form, which will bring this down as low as 20 per cent., a great gain, indeed, in our present treatment, compared with the statistics of only fifteen years ago. But the importance of searching in particular for the bacillus of Loeffler seems to me most imperative with reference to the measures to the taken against its spread at its first appearance.

Dr. W. R. Cleaveland, of Biggs: My views of the treatment of diphtheria are very much in accord with those of the reader of the paper. I am not a microscopist, and I am not able to say from personal knowledge any thing whatever in regard to the microbe which causes the disease, but I am satisfied, from experience, that the early and effective use of such remedies as are suggested is effective in very many cases which would, I believe, be otherwise fatal. Constant attention to the diet of the patient, who must be well supported, is very essential.

Dr. David Powell, of Marysville: I have had very little experience with this disease during the last few years. Like Dr. Cleaveland, I am heartily in accord with Dr. Stansbury in treatment. I think there can be no doubt that the remedies he has mentioned are the ones to adopt. Of course, there are differences of opinion in regard to the treatment of the disease, and in regard to what antiseptics are best to employ. And while there are so many differences of opinion in regard to what is best, perhaps there can be but very little choice. I would like to ask Dr. Stansbury whether he has discontinued the use of the bichloride that has been so highly recommended? I remember using it some years ago but not with benefit in that particular case.

The President, W. A. Briggs, of Sacramento: I think the author of the paper struck the key-note of the treatment when he dwelt on the importance of early and persistent treatment. My observation of diphtheria leads me to believe that, in its incipiency, treatment is very effective, but when the disease has made progress, has been in existence two or three days without recognition, and has spread over a large surface, even the nasal cavities, then we must rely largely on the inherent resistance of the patient, and stimulation by alcohol. When the disease is incipient and when the membrane is forming, by the use of solvents and antiseptics of one kind and another, I believe we can prevent the extension of the disease and of secondary infection. In these cases my observation has been that we can reduce the mortality to fifteen or twenty per cent.

Dr. Stansbury, in reply to Dr. Powell's question, said: The bichloride was recommended to me by Dr. Tooley, of Willows, who has had some experience with it. He recommended it so highly that I used it, and I lost the two cases in which I used it. That is my only experience.

The Decline of Maternity; Its Causes and Treatment.—**David Powell**, of Marysville, read an exhaustive paper on this subject. He reviewed at length the opinions of political economists on the question of increase of population beyond the possibilities of a country to support it, and the failure of natural laws to check this increase when the conditions of the people had fallen to a level below the plane of decency and comfort. He next alluded to the growing infertility of marriages amongst the civilized nations, and to the number of marriages that were absolutely childless. This he believed was attributable to the increasing cares and demands of fashionable life, to the character of female education, and to the neglect of physical culture. A far more efficient cause than the foregoing was the deliberate restraint practised in many families that would otherwise prove fruitful. Young ladies of modern times knew too many things, and their knowledge was not conducive to posterity. Of late years the education of young married women was not neglected. There were few communities that were not visited by some lecturer—a female adventuress—whose mission it was to diffuse a certain kind of knowledge, and "to reform the marriage relations." Woman thus came to regard maternity as an intolerable nuisance, and a large family as a disgrace. They are thus taught how they may avoid the privation of social and fashionable pleasures. In fact, the Malthusian idea was much more in accordance with popular sentiment than at the beginning of the century. This was not due to an increase that was endangering the general welfare of nations, but because the theory was more in consonance with modern ideas. The speaker next turned to the crime of feticide, which he said was becoming alarmingly frequent. Means towards this end were unblushingly heralded in the daily papers, and by means of the vilest publications. In concluding a most interesting paper, the speaker said that he did not know what power might be invoked to overcome the perverted unwomanly sentiments at present prevailing. "A purer and more exalted conception of the purposes of marriage; a better appreciation of the mutual obligations it imposes; probity of life, and the cultivation of abstemious and frugal habits, and domestic attachments among men; the higher education; a more intelligent contemplation and observance of nature's beneficent laws; and the greater advancement of an ideal Christian civilization, may, in the future, overcome erroneous ideas, customs, and habits of thought; lead to a more natural, rational, and healthy spiritual and physical existence, and to the transmission of sounder theories and doctrines of social science to an increasing and more enlightened posterity." [To be published.]

DR. J. H. PARKINSON: I regret exceedingly that my professional occupation during the past few hours, assisting at the increase of maternity, prevented my hearing all of this paper, which shows considerable research and which is excellent in construction. It states the case so very fully as to leave but little to discuss and merely an opportunity to comment. The decline of maternity, the very obvious decline, in this country more than in any other, especially among the native-born population, is one that interests us alike as physicians and as citizens, perhaps not wholly unselfishly as the former. In this country at least, the causes are, perhaps, three-fold: (1) The very general habit of preventing conception in marriage. (2) The prevalence of infertility. (3) That too common crime, to which the author has alluded, the crime of feticide. There is no question, to one even of limited observation, in this country, that the native-born population show a greater degree of infertility in the marriage state; that is, judging from results; because it will always be impossible in any but a limited number of cases to ascertain the facts. It is true that the cause of these childless marriages may be an inability on the part of one or the other of the parents; but it is also true that the tendency to restraining fertility is most prevalent among that class of population, and equally true that the foreign-born population very readily become educated, and that the second generation is fully as competent as those who were here before them. It seems to me that the reasons for attempting to limit the number of offspring is not altogether the fault of the woman, for in a great many cases the man is undoubtedly a consenting party, and from more selfish motives than the woman. On her falls the hard burden of maternity, of the marriage relations, of child-bearing, and of the subsequent care of the child; and if the man insists or suggests in this direction, his motives are certainly less free from suspicion than those of the woman. As the author has well said, to suggest a remedy for these cases, or to suggest a rule whereby prevention might be properly applied, is impossible. It certainly is so to any man of ordinary or average intelligence. We can make a rule for different cases, but there must be many exceptions to that rule, and I do not know of any proposition in which we will find a solution to this grave problem.

AFTERNOON SESSION.

Gastric Ulcer.—W. E. BATES, of Davisville, read a paper on this subject. He said the pathology of this affection could be summed up in one word, "necrosis" of one or all of the coats of the stomach, due to one of several conditions. Repair only took place when the morbid condition that originally started the process had been removed, when cicatrization would set in. The speaker reported several cases that had been under his personal observation. In the first case the loss of blood had been enormous and was unchecked by any measures that could be employed. The patient died three days after the commencement of constant hemorrhage. At the autopsy an ulcer on the posterior wall of the stomach and close to the pylorus was discovered. The base of this ulcer was the pancreas, to which the stomach had become attached, and in the floor was a large vein through which the hemorrhage had occurred. In another case, patient had complained for several months of pain in the abdomen just below the costal cartilages of the seventh and eighth ribs on the left side. . The passages were flat and ribbon-like, and a diagnosis of gastric ulcer with adhesions to the transverse colon was made. This patient was a younger brother of the patient whose case has already been reported, and the symptoms dated from an injury received from the tiller of a header. Under treatment, the symptoms improved, and the stricture was subsequently relieved by dilatation. During the process of dilatation, and when the instrument was passing the stricture, the same sensations were experienced as when the trouble was in the acute stage. The third case occurred in an intemperate subject, the symptom first attracting his attention being an attack of icterus. There was no hemorrhage, but well marked local pain. After appropriate treatment, recovery from the local symptoms seemed to occur, but the gastritis that had been present continued, as patient would not submit to continued treatment.

DR. J. T. HARRIS, of Gridley, thought the plan of treatment was good. He had seen some cases of gastric ulcer and they had ended in recovery with something like the treatment mentioned by the author. It was quite likely that he had seen other cases but had not made a positive diagnosis regarding the presence of ulceration.

DR. T. W. HUNTINGTON, of Sacramento: I have been for a long time impressed with the subject of gastric ulcer, both from a diagnostic and from a therapeutic standpoint. Three varieties or stages of gastric ulcer are recognized: (1) That involving the mucous coat of the stomach. (2) That involving the mucous and muscular coats. (3) The perforating ulcer which involves the peritoneal coat, together with the two already named. Pain is usually noticeable during the first and third stages, but is more acute during the latter, when there is accompanying peritoneal inflammation. Hemorrhage is more common during the second stage. The use of arsenic during the earlier history of this disease, as recommended by Bartholow, has undoubted merit. Its action, however, is probably attributable to its influence upon the general nutrition rather than to its topical effect. Recently attention has been called to the fact that perforation of the stomach, with its unfortunate results, may be successfully met by operative interference. Cicatricial contraction of the pylorus, a well known sequel of gastric ulcer, has been relieved by Loreta's operation. A case operated on by me some years since, is now well, and the patient earns his livelihood by hard labor.

DR. BATES: I would like to say something about the first case I mentioned. I found I could not check the hemorrhage with medicine, and as they are a long-lived family, I thought the patient could stand an operation; but the parents were not willing—they would not hear of it. The young man's father was then 89 years of age, and said he would rather see his son die whole than to be cut open. The autopsy proved that it would have been fatal, and that the operation could not have been successful.

In the absence of the author, A. W. HOISHOLT, of Stockton, his paper entitled "A Case of Procursive Epilepsy," was read by J. H. Parkinson, of Sacramento. [Published at p. 177.]

DR. E. E. STONE, of Marysville: Dr. Hoisholt's paper is very interesting, and as we who have country practices have rarely the chance of seeing these cases, it is quite a treat. I have had no experience with the peculiar class of cases that he speaks of.

DR. T. W. HUNTINGTON, of Sacramento: I would like to have asked the author of the paper, had he been present, whether he had any theory upon which he based the beneficial use of borax.

Dr. J. H. Parkinson, of Sacramento: I think Dr. Hoisholt did not fully bring out a point that would have been of considerable interest, no doubt, to all of us, and that is, the legal responsibility of the individual whose case has been reported. The author mentioned it when he said it was a question whether the patient was not aware of what he was doing, and whether he was not governed by the will at times. In this case, a young man runs away from home, meets a horse, mounts it, and becomes a horse thief for the time being. Again, he endeavors to strike a man, and remembers he did intend to strike that same individual. Would it not be possible for the same influence to return as an imperative delusion when he was once more free? In this case, if violence were done to any one, could the epileptic be legally held responsible?

Dr. B. M. Gill, of Dunsmuir, presented a paper upon puerperal mania, which, in his absence, was read by the Secretary. The author said that this disease depended upon or was at least strongly influenced by an unstable condition of the nervous system, as seen in the so-called neurotic temperament. Its development is favored by any depressing influence, such as persistent insomnia, malnutrition, and insufficient care in the puerperal period. It is rarely attended by either homicidal or suicidal tendencies and the prognosis, in the earlier stages, is favorable. In the treatment of these cases absolute rest should be secured and the fullest nutrition maintained. It was very desirable that lactation should continue and it was not advisable to wean the infant.

Dr. W. R. Cleaveland, of Biggs: My experience with puerperal mania has been limited to two or three cases. I believe the measures suggested would be beneficial.

Dr. W. W. Macfarlane, of Davisville: I have seen a good many cases, not in my own practice, but from that of others. The rule is, they recover if anything like proper attention is given them. Any case that has lost a good deal of blood, especially if the subject be of a neurotic temperament, is liable to have puerperal mania. The point to which I wish particularly to refer is that the author of the paper mentions that these patients are not homicidal or suicidal. The rule is they are both. It is not at all uncommon for them to kill the baby if they have an opportunity, and probably the whole family. It is not at all uncommon that they hate their relatives and their own friends, and would kill them if they had an opportunity to do so. That is the rule with cases of puerperal mania. The best treatment that I have ever tried in cases of this kind is morphine and cannabis indica. I have found that it relieves them better than anything else. It is best to have them removed from their families, and the best place is the asylum. That is the place to which they ought to go. You never know when they are going to do mischief, and if they are removed from their relatives and acquaintances and put in the asylum, the rule is they recover, and generally within twelve months, although I have seen cases which have taken five years for recovery.

The President: Do you agree with the author of the paper in drying up the milk? Do you think this secretion should be checked?

Dr. Macfarlane: I never heard of it before. That is a new idea to me. I do not believe that I have ever had a case in my own practice. I have seen them in the asylums and I have seen them a few weeks after they had become insane, and of course the milk had been already dried up. It is possible there may be something in it but I cannot say.

Dr. W. E. Bates, of Davisville: I had a case a year ago that had been in the asylum. I was called to Dixon to deliver a woman, but the child was born before my arrival. There was a severe laceration of the perineum, which I repaired as thoroughly as possible. This was the woman's second child; she was of a neurotic temperament and she had lost considerable blood. About four months after the birth of the child she became insane, the mania being of a religious type. She would lie in bed and throw her hands up and say, "O Jesus! O Jesus! O Jesus!" and keep that up day and night. She would just clasp her hands and say "O Jesus! O Jesus!" We tried in every way to quiet her, and after consultation with Dr. W. R. Cluness, we decided to send her to Napa. She stayed there three or four months, came home, stayed a couple of months, and broke down again. She was taken back to the asylum and is as crazy now as she can be, on religious subjects, and no treatment has, so far, done her any good.

Dr. Macfarlane: After seven confinements I have known a woman to be insane and to be taken to the asylum; but three or four of the family had been insane. She had a brother and a sister in the asylum at the same time she was there.

Some Peculiar Effects of La Grippe Poison.—H. D. Lawhead, of Woodland, said he had selected this title, believing that *la grippe* was something more than influenza. It was true that the terms had become interchangeable, and that in the latest dictionaries the words were bracketted as synonymous. In accepting this position, however, we did ourselves and our patients a great injustice by minimising the importance of a very grave disease. The speaker then briefly referred to several cases in which the nervous symptoms had so predominated that a diagnosis of meningitis, or even of a graver organic lesion, would have been justified. In several cases he had also noticed a despondency so marked as sometimes to amount to suicidal mania. Another peculiar feature of this disease was the temperature, which was often exceedingly high without any corresponding increase in the pulse or respiration. This very high temperature would then subside without prolonged and often without even active treatment. The possible mode of influence of the poison on the nerve centers was next discussed, and the treatment was briefly dismissed by a strong objection on the part of the author to the indiscriminate use of the coal-tar products.

Dr. T. P. Peary, of Yuba City: It seems to me that the question of etiology is as yet hardly settled. In speaking of it as being a nervous disease, I think there are arguments against that theory; but it is not in my power to throw any light upon it. I wonld like to know if any one has noticed one symptom that has been present in epidemics—that of confusion of mind? The patient becomes despondent, and this continues for some length of time.

Dr. E. K. Caldwell, of Blacks: Regarding the connection between suicide and *la grippe*, I recollect three cases where it seemed to me this was quite evident. In one case the patient took about half a can of rat poison. Concerning the treatment, I think the depressed condition brought about by the salicylates does more harm than good. This has occurred to me not only in my own practice but in that of others; and while it rarely produced a fatality, I have certainly had much better results by general stimulating treatment.

Dr. J. P. Gale, of Arbuckle: There is one point that makes the treatment of this disease most unsatisfactory; that is, a great many persons undertake to treat it at home. The disease is not recognized as a serious matter, for it falls under the head of "bad colds." Whenever we treat these cases the friends think we should have a little better success than we have had, on account of the obstinacy of the case. We may do all we can by stimulating, and, when the temperature is high, giving something that does not depress the system, but recovery is slow. I think this is the reason why many find it so unsatisfactory a disease to treat, because of its very general prevalence, and also the number of severe cases, between which and the milder ones people do not discriminate.

Dr. Lawhead, of Woodland: In regard to the question whether suicidal tendencies are present in cases of coryza, I am unable to offer an opinion. I do not recall any symptoms pointing to that; and, in fact, I do not recall any instance where a patient complained of any of these symptoms.

Abortion; Its Causes and Treatment.—W. R. Cleaveland, of Biggs, in a paper on this subject, reviewed the causes and premonitory symptoms of abortion, which he distinguished from the later termination of a pregnancy in premature labor. He then reported several cases, some of which illustrated the amount of interference that the uterus would tolerate without losing its contents. He believed that there was great danger, if the modern teaching was to be universally followed, of emptying the uterus as soon as it had been determined that abortion was inevitable. When this procedure was undertaken by men who were not thoroughly familiar with the principles of antiseptic treatment, harm was certain to be done. It was not enough to carry a vial of bichloride tablets in one's pockets; in fact, this, by inducing a false security, was in itself an element of danger. Asepsis should be studied, and thus true safety could be realized. The practitioner should be prepared to operate, and, by being always ready and properly equipped, he can then pursue what is undoubtedly the safer course by promotly emptying the uterus.

Dr. J. H. Parkinson, of Sacramento: One point occurred to me while listening to the paper, and that is in connection with curettage. It has always seemed to me that the blunt or dull wire curette is only a little more useful than the finger; but it is not to be relied upon, except to remove loose tissue. I do not know that the author implies anything else. If any thing more than that is to be done, it must be with cutting instruments, and if the uterus is to be thoroughly cleaned out the sharp curette is the only one to use.

Dr. W. W. Macfarlane, of Woodland: I will only make a remark about one point in this paper, and that is, the use of the tampon; not that I object to the tampon, but when it is employed it should be efficient and of good size. I know persons who use the tampon, and who will have a little wad of cotton that you could run your finger all around, and you might just as well have nothing at all. I have seen half a dozen little wads of cotton, with a string tied to them, removed. It would have been better if they had had no tampon. If a tampon is used, it should be effectively inserted; but a great many, in using tampons, have them so loose that they are absolutely valueless.

Dr. E. K. Caldwell, of Blacks: We have all had experience with this class of cases. In times past they have been the most unsatisfactory and the most distressing to treat of any that have come under my notice. I have always been afraid that I was not doing my whole duty. My practice of late has been, where there was any indication for removal, to insert a pencil of iodoform; and it seems to me those cases have proven much more satisfactory, and have given good results. I sometimes insert a piece of cotton rolled up with iodoform.

Dr. W. E. Bates, of Davisville: I would like to agree with the last speaker, and also with Dr. Macfarlane, about tamponing. Put the tampon well into the os. In country practice I always feel that when I do that with a woman 10 or 12 miles in the country, I can leave with safety. I do not think that the author laid quite enough stress on the removal of the decidua. I never feel satisfied unless I can dilate the os so that I can sweep my fingers over the whole lining of the womb.

Place of Next Meeting.—The next meeting of the Society being the annual meeting, it was thought best to hold it in as central a location as possible. Marysville was accordingly chosen, and the Society adjourned to meet in that city on Tuesday, October 9, 1894.

New Members.—At the different sessions of the Society the following were duly elected members:

E. K. Caldwell,
J. P. Gale,
W. W. Macfarlane.
H. M. Kier,
L. Welges,
M. W. Ward,
E. M. Yates,

CORRESPONDENCE.

Code of Medical Ethics of the American Medical Association.

Dear Sir: In reply to your inquiries concerning the Code of Medical Ethics, I desire to say, that after a careful study of our National Code, both theoretically and practically, for more than half a century, I find its scope so complete, and the principles it inculcates so plainly and concisely stated, as to constitute it a safe guide for regulating every interest belonging to the medical profession. Consequently, in the language found in next to the last paragraph of the brief report of the Committee on Revision of the Code, at the last annual meeting of the Association, I earnestly "deprecate all efforts to abolish, belittle, distort, ridicule, or otherwise lessen its hold upon the profession. It is a heritage, representing at once the best characteristics of our profession during all its history, and a scientific document that points out the line of greatest prosperity in the future." Surely if these statements are true, the highest wisdom dictates that it should be preserved in its entirety, and be adopted by every regular medical society organization in our country, and be cheerfully obeyed by every honorable member of the medical profession. I therefore can see no adequate reason for altering, amending, or revising it in any particular. And yet, with singular inconsistency, a majority of the same committe whose eulogistic words I have quoted, in the same report recommend the entire omission from the Code of the ten sections relating to the obligations of patients to their physician, and of the public to the profession. They base their recommendation solely on the pretext that the Code was not designed for the patients or the public, which is a serious error. It was designed both for the public and the profession; and if members of the latter had taken more pains to see that copies of the Code found their way into the hands of a large proportion of their more intelligent patrons, it would have greatly promoted the interests of all parties. But even if it was true that the Code was not for either patients or the public, it is certainly as desirable that the physician should understand as clearly what he has a just right to claim from his patients and the public, as what they have a right to claim from him. Therefore, to strike out the ten sections as proposed would seriously impair the completeness of the Code. The majority of the same committee also recommend the omission of the clause prohibiting the members of the profession from holding patents on surgical instruments and appliances used in the practice of medicine and surgery. And what is far more important, they distinctly urge the abandonment of one of the fundamental principles on which all that is of real value in the Code rests, namely: that "a *regular* medical education furnishes the only presumptive evidence of professional abilities and acquirements, and ought to be the only acknowledged right of an individual to the exercise and honors of his profession. Nevertheless, as in consultations the good of the patient is the sole object in view, and this is often dependent on personal confidence, no intelligent *regular* practitioner who has a license to practice from some board of known and acknowledged respectability, *recognized* by the *Association*, and who is in good moral and professional standing in the place where he resides, should be fastidiously excluded from fellowship, or his aid refused in consultation when it is requested by the patient." It will be seen by a careful reading of the foregoing quotation from the Code as it is. that the right of any person to recognition, fellowship, and consultation, is the possession of "a regular medical education," "good moral and professional standing," and "a license to practice from some board of known respectability, recognized by the Association." In other words a genuine medical education and a good moral character, are the essential requirements for recognition. But the majority of the Committee on Revision, by carefully omitting the word "*regular*" and the words "recognized by the Association," and inserting instead "*legal* authority to issue such license," completely nulifies the educational and moral standard of recognition and the right of the profession to enforce it, and places the essential basis of recognition wholly on the "license to practice from some board of known and acknowledged *legal* authority to issue such license." And this is proposed by members of a committee, every one of whom knew perfectly that several of the States have no medical boards, others have three or four boards, each with a different standard, and still others have one board composed of representatives of all the '*pathies* and '*isms*, and all of these multitudinous and heterogeneous boards, as well as all the medical schools in the country, have "known and acknowledged legal authority to issue" licenses or diplomas. I hope and confidently believe that such proposed changes in the Code will find no favor among your readers; but contrarywise, that the enlightened regular profession of the whole Pacific slope will sustain the Code as it is, and the right of the profession to enforce its honorable and just provisions. Yours truly, N. S. DAVIS.

CHICAGO, Ill., March 21, 1894.

Dear Sir: The fact that the meeting of the American Medical Association is to be held this year on your side of "the Rockies," places a grave responsibility on the medical profession of the Pacific coast; for naturally that section will have a larger proportionate representation, owing to the great distance of the place of meeting from the Atlantic States, hence the gravity of the questions relating to proposed changes in the plan of organization of the Association requires careful consideration at the hands of our occidental *confrères*. The very fact of this location for the June meeting should be a strong argument for the retention of the plan of voting by delegates only, as the only means by which the Association can maintain a representative body. I feel that the

Association will be "in the hands of its friends" when at San Francisco, and that when the vote on the proposed changes in the Code of Ethics is taken, that our western friends will not feel disposed to emasculate that document, or make the changes sought by its enemies. Though the agitation for a "more liberal Code" began and has been mainly fostered in the east, there is still a large majority here opposed to any change, and in particular changes sought by its enemies. Unfortunately, that large majority is made up so as to include the general practitioners, many of whom cannot attend the meetings. Personally, it is my purpose to be with you. It is my sincere hope that no change will be made in the Code, and none of the radical changes in the Constitution, as proposed at Milwaukee. Yours, etc., E. D. FERGUSON.

TROY, N. Y.

REVIEWS AND NOTICES.

NEW TRUTHS IN OPHTHALMOLOGY, as developed by R. C. Savage, M.D., Professor of Ophthalmology in the Medical Department of the University of Nashville and Vanderbilt University. Thirty-two illustrations. Nashville, Tenn.: Published by the author. Pp. viii, 152.

The author writes on fourteen different topics, and develops several new theories. There may be, we think, a reasonable doubt as to appropriateness of the title "New Truths." Some of the propositions are undoubtedly truths, but some of the questions discussed have not been sufficiently developed to be accepted as truths by the profession. A large part of the volume is devoted to anomalies of the ocular muscles. A theory is propounded on the influence of the oblique muscles on cases of oblique astigmatism, as well as several other new theories. A simple and we believe an efficient modification of Panas' operation for entropion is described. There are a number of good articles on new and important subjects which are worthy of the attention of all interested in the progress of ophthalmology.

A TEXT-BOOK OF THE THEORY AND PRACTICE OF MEDICINE BY AMERICAN TEACHERS. Edited by William Pepper, M.D., LL.D., Provost and Professor of the Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania. In two volumes, illustrated. Vol. I, pp. xii–910; Vol. II, pp. xii–1046. Philadelphia: W. B. Saunders.

This text-book will undoubtedly prove one of the most successful of the series that W. B. Saunders has so far issued. Intended as a companion to the "American Text-book of Surgery," it is, however, on a more extended scale; yet in the effort to keep it within reasonable limits the second volume has exceeded the first by over 100 pages. Volume I commences with a practical and timely article on hygiene, by John S. Billings, occupying 45 pages. Then follow in order the exanthemata with other diseases—infectious and parasitic. The volume closes with diseases of the nervous system. The last division has been treated by Osler and Horatio C. Wood. James T. Whittaker treats the parasitic diseases and those, as hydrophobia and glanders, that can be communicated from animals to man. Nearly 200 pages of this volume have been written by the editor, who has taken the exanthemata as his special field. Volume II opens with an excellent article by William H. Welch on the biology of bacteria, and including infection and immunity. This is a really valuable contribution of the very latest knowledge on the subject, and will materially assist in the comprehension of the phenomena of disease in the light of modern research. Following this, Henry M. Lyman treats of the diathetic diseases. Osler writes on the blood and the suprarenal capsules; Delafield on diseases of the kidneys; and urinary examination receives attention from James T. Holland. To this volume the editor is again the largest contributor, having written 325 pages. The trend of specialism is shown, by the fact that no mention is made of diseases of the eye or of the ear, while the morbid processes of the nose, throat, and larynx are fully treated. Illustrations have been used wherever it seemed appropriate. Many of them are from photographs, and are therefore accurate reproductions of the processes illustrated. There are a number of colored lithographs, and in all this matter of illustration originality and freshness is most apparent. Taken as a whole, this work is most creditable to

American medicine, and is well calculated to bring into notice abroad the fact that the United States is not lagging in the matter of scientific knowledge or practical work. It is the latest text-book on this subject, and cannot be too highly commended as a source of reference or for constant study. The typographical work is excellent, and the publisher may have justifiable pride in stating that the mechanical part of the book, including the printing of the colored plates, was carried out in his own establishment.

HERNIA; ITS PALLIATIVE AND RADICAL TREATMENT IN ADULTS, CHILDREN AND INFANTS. By Thomas H. Manley, A.M., M.D., Visiting Surgeon to Harlem Hospital, etc., etc. Philadelphia: The Medical Press Co. (Limited), 1725 Arch street. 1893.

To write a book upon any subject with which the author is fairly familiar is a comparatively easy task. To write a good book, one which shall add to the sum of our general knowledge, which shall give to the world the result of original research, or furnish the reader with the consensus of opinion of many authorities, is a different proposition. The subject of Hernia has, during the past ten years, attracted wide-spread attention, and the recent literature devoted to this topic is, in the main, a valuable accession to the medical and surgical profession. The reader of Dr. Manley's monograph cannot fail to be impressed by what seems to be a notable carelessness or recklessness throughout in point of construction and method of expression. The author's plan of procedure is, in many respects, commendable, and it is to be regretted that the proof-sheets of the work were not submitted to careful revision and thorough pruning. Here seems to be a case of spoiling the materials of an ample feast by unworthy cooking.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held March 10, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

D. G. Allinder, Chicago, Ill.; Med. Dept. Univ. of Pennsylvania, March 13,'69.
James M. Applewhite, Stockton; St. Louis Coll. Phys. and Surg., Mo., March 8,'89.
Edgar Chester Atkins, Riverside; Harvard Univ. Med. School, Mass., June 28,'82.
George Henry Barney, Pasadena; Rush Med Coll., Ill., Feb. 21.'77.
Samuel Augustus Binion, San Francisco; Univ. of Maryland School of Med., Md., Mar. 17,'86.
Charles Allen Brown, Duarte; Med. Dept. Vanderbilt Univ., Tenn., March 1,'85.
Frederic Clift, St. George, Utah; Keokuk Med. Coll., Reokuk, Ia., March 10,'91.
Robt. L. Doig, San Diego; Coll. Phys. and Surg., Keokuk, Ia., March 2,'80.
David Roberts, Redondo Beach; Starling Med. Coll., Ohio, March. 3,'92.
Andrew Mitchell Henderson, Sacramento; Cooper Med. Coll., Cal., Dec 7,'93.
Nathaniel S. Lane, National City; Chicago Med. Coll., Ill., March 20,'77.
Phillip S. Lindsey, Santa Monica; Med. Dept. Bowdoin Coll,, Me., May 29,'88.
John McMillan, San Francisco; Rush ~~Med. Coll., Ill., March~~ 25,'90.
Harry O. Miller, Cloverdale; Cooper Med. Coll., Cal., Dec. Dec. 7,'93.
Francis Joseph Tood, Oakland; Med. Dept. Univ. of Michigan, June 28,'83.
Anita E. Tyng, Pasadena; Woman's Med. Coll., Pa., March 16,'64.
James C. Whitehill, Los Angeles; Med. Dept. Univ. of Pennsylvania, April 5,'51.
Albert Williams, San Francisco; Univ. of Aberdeen, Scotland, M. B. & C. M., April 23,'68; M. D., April 23,'72.

CHAS. C. WADSWORTH, Secretary,

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from Feb. 20 to March 20, 1894.

Leave of absence for one month, to take effect on completion of the duties assigned in Special Orders, No. 35, current series, Headquarters of the Army, A. G. O., about the 3d proximo, is granted Major Timothy E. Wilcox, Surgeon. Par. 1, S. O. 11, Dept. of the Colorado, February 24, 1894.

First-Lieutenant Paul F. Straub, Assistant Surgeon, is relieved from duty at Fort Riley, Kansas, and ordered to report in person to the commanding officer, San Carlos, Arizona, for duty at that post, relieving First-Lieutenant Harlan E. McVay, Assistant Surgeon. Lieutenant McVay, on being relieved by Lieutenant Straub, will report in person to the commanding officer, Whipple Barracks, A. T., for duty at that post.

First-Lieutenant Charles Willcox, Assistant Surgeon, is relieved from temporary duty at Boise Barracks, Idaho, and ordered to return to his proper station, presidio of San Francisco, California. Par. 7, S. O. 54, A. G. O., March 5, 1894.

A board of officers, to consist of Lieutenant-Colonel Charles R. Greenleaf, Deputy Surgeon-

General; Lieutenant-Colonel Albert Hartsuff, Deputy Surgeon-General; Major Benjamin F. Pope, Surgeon, is appointed, to meet at the call of the president thereof, at San Francisco, Cal., for the examination of Captain William R. Hall, Assistant Surgeon, with a view of determining his fitness for promotion, as contemplated by the Acts of Congress, approved October 1, 1890, and July 27, 1892. Captain Hall will report in person to the president of the board, for examination, at such time as he may designate.

Leave of absence for one month is granted Major Timothy E. Wilcox, Surgeon.

The .eave of absence granted Major John D. Hall, Surgeon, is extended one month.

ITEMS.

Dr. G. B. Wilson has removed from Johnson, Washington, to Pullman, Washington.

Dr. S. B. Swift, formerly physician in charge of the leper settlement at Molokai, H. I., is now located at Santa Rosa, Cal.

Dr. J. Dennis Arnold has removed from Chronicle building to 530 Sutter street, San Francisco, Cal. Hours, 10 to 1. By appointment only, 2 to 4.

A Correction.—In Dr. F. W. Vowinckel's remarks, as reported in our issue of March, on page 159, when discussing Dr. Kreutzmann's paper, several mistakes occurred. The speaker should have said: "Dr. Kreutzmann was mistaken, Mackenrodt did put stitches through the plica vesico-uterinæ." Regarding the relative merits of chloroform and ether, the speaker said: "He also was afraid to use ether in cases with any lung or bronchial trouble and in those cases preferred chloroform. Patients with well compensated failure of the valves of the heart stood chloroform generally well. Death from chloroform was usually not due to such a complication."

Association of Military Surgeons of the United States.—The Fourth Annual Meeting of the Association of Military Surgeons of the United States will be held in Washington, D. C., May 1, 2 and 3, 1894. This national organization is composed of medical officers of the U. S. Army, U. S. Navy, National Guard of the United States, and the Marine Hospital Service. A brilliant and able literary programme will be presented. The afternoon of one day will be set apart for an object lesson from the "Manual of Drill," by the Hospital Corps. The evenings will be given up to social entertainments. There will be about five hundred delegates in attendance. George Henderson is the Chairman Committee of Arrangements.

A Student's Ophthalmological Society.—The students of the Medico-Chirurgical College of Philadelphia have formed an Ophthalmic Society within their ranks. This is the first society of the kind organized in any college in the country. It is called "The L. Webster Fox Ophthalmological Society of the Medico-Chirurgical College of Philadelphia," and is composed of members of the senior class. As these graduate, their places will be filled by members of the junior class. It is intended, however, to make the Society a permanent and an influential one. With this object, graduating students will still retain their membership in the Society. It is proposed to hold an annual banquet, at which a general reunion will take place. Leading eye specialists in every State will be admitted to honary membership.

Occidental Medical Times.

Vol. VIII. MAY, 1894. No. 5.

AN ADDRESS,

Delivered at the Opening of the Twenty-fourth Annual Meeting of the Medical Society of the State of California, April, 1894.

By C. G. Kenyon, M.D., President, San Francisco, Cal.

Ladies and Gentlemen, Members of the Medical Society of the State of California: Before proceeding with the business for which we have assembled, I desire first to thank the members of this Society for the honor conferred on me in my election to the high office which, at the adjournment of this convention, it will be my duty to surrender to the one whom you may choose to preside over you for the ensuing year; and secondly, to congratulate those present and our absent members on the favorable auspices under which we are here assembled. Your presence in such large numbers, the animation which pervades this assembly room, the very elaborate and extended programme laid before you, embracing reports in the various sections, and a large number of contributed papers of more than usual interest, prompt me to express the belief that this, the twenty-fourth annual meeting of the Medical Society of the State of California, convened this lovely morning in the Garden City of the Golden State, will be long memorable in the history of our organization, as one fruitful in honest and valuable work in the cause to which we, as members of the profession, have devoted ourselves. That this belief may be fully realized, is my earnest hope; and that I am not alone in this hope, is apparent from the enthusiasm manifested on all sides in this assembly room.

The Architect of the Universe has, with lavish hand, bestowed his benefits upon our State and upon the various sections of the State that we severally represent. A soil which, under the touch of the husbandman and the influence of an unequaled and varied climate, brings forth in abundance the fruits and products alike of the temperate and of the tropical zone. And where, in all the broad domain of our sunny California, do we find a section more richly blest than this Santa Clara Valley, enclosed about with mountain side, bedecked throughout its entire length and breadth with happy homes, and in its center seated the beautiful Garden City, lovely San José, famed throughout our State for its wealth, its culture, and its learning? Our profession is ably represented in this hall by a large delegation of the resident physicians, who have ever kept abreast with the general onward march of the times, no feature of which is more marked than the great strides taken by our science in the triumphal procession.

This Society has in time past honored itself by conferring its presidency upon a representative medical gentleman, long a resident of San José, Dr. W. S. Thorne. Who is there among us who does not remember with respect the names of two distinguished physicians of this city who have put off the harness and passed to a well-earned rest, and who in their lives were known throughout the State as men, the peers of their fellows, not only in professional ability, but in all that goes to make up the character of man? Need I say that I refer to Dr. Spencer and Dr. Saxe?

By reference to your programmes, you will perceive that the entire time of the meeting is devoted to the presentation and discussion of subjects of a scientific character, and hence, whatever comes before you bearing upon the general standing and progress of the profession throughout the State must find place in the address of the gentleman welcoming you, and in that of the President. In looking over the field, many matters seem worthy of space and of your attention. I will, in the limited time allowed me, call your attention to some of them.

Surrounded as I am by so many who have become eminent in our profession, I can hardly flatter myself that many here expect to learn any thing new from a president's annual address, and it is more than probable that if any did their expectation would be disappointed. But an annual address is a time-honored custom, and it seems to me that its office is less to impart information than to give public expression to, and, perhaps, to afford opportunity for, more general discussion of ideas, which, no doubt, have often suggested themselves to many individual members. With this short prelude, I propose to mention briefly a few matters which, I think, concern the good and the welfare of our Society, claiming for myself no merit as an original discoverer, and leaving it to this convention to determine for itself to what extent, if any, the suggestions now presented are acceptable to the majority of its members.

It is quite the fashion, in addresses by medical men, for the speaker to lament, in a pessimistic mood, the deplorable lack of higher education and general professional attainments in the profession in our own country, as compared with the standard in other, older, and, especially, European countries. To these jeremiads I desire to offer my humble protest. While my voice will always be uplifted in favor of the best type of manhood, and the highest standard of attainments, as pre-necessary qualifications for those who would assume the honorable title of M.D., yet I am pleased to call your attention to the general activity and earnestness displayed by the profession within the influence of this Society, and I venture the assertion that, striking a general average of the profession in California, no body of men can be found under the sun better informed and more capable as a whole than we have here. In proof of this assertion, I refer you to the high standard adopted by our medical schools, the vast amount of medical literature, local and foreign, received and supported by our profession; the prevalent custom among our young men to go abroad to further qualify themselves, in wider fields, for professional work; and the general activity exhibited in our local and State organizations.

That this Society is an important, and may be made to become a more important, factor in maintaining this standard of excellence, is a statement which I need hardly make here. Your presence as members of this organization, many of you coming great distances from your homes to attend this convention, testifies to your appreciation of the fact. This being so, is it not well that we should consider whether by any, and if by any, by what means we may best extend and widen this Society's sphere of acknowledged usefulness? The scientific, financial and numerical strength of this Society has not materially changed during the year. We are an old concern, well established, and prone to pursue our even way in well-worn paths. We have our annual meetings conducted upon the same lines as the last and the one before. We collect our dues, pay the current bills, elect a few new members, drop a few others for nonpayment of dues, keeping our membership about the same from year to year. It is found to be good policy in old and solid commercial institutions to engraft new blood and energy in their management. Is there not a lesson in this which we may, with profit, take to ourselves? I propose to offer for your consideration some changes in the constitution and by-laws of this Society, with the end in view of increasing our membership, our working capacity, and our power of advancement of the profession within this State.

We are pleased to call this organization "The Medical Society of the State of California," a very high-sounding and comprehensive title. But when we consider the fact that out of 2,700 licensed practitioners of regular medicine in the State our membership consists only of some 360, it becomes apparent how short we fall of fulfilling the high and important mission which our title, and our objects as declared in our constitution, would indicate.

As I have before intimated, we may assume. without argument, that membership in this Society is beneficial to the members and to the advancement of our science. It becomes, then, our duty to consider the proper and best course to pursue to extend those benefits to the utmost limits. That we have been only partly successful under our present plan of organization, is too patent to require discussion. Having given this matter much thought and consideration, I desire to bring before you some suggestions, which, if they are found worthy of your approval, will, I believe, increase our membership and extend our field of usefulness.

Reduction of Annual Dues.

First: I would suggest the reduction of the annual dues from five dollars to three dollars. The accumulation of funds is not a purpose of this Society, and cannot become so unless the objects for which it was originally organized be changed. Those objects, as stated in Article I, Section 2, of our Constitution, are: "To encourage the unity and harmony of the said profession throughout the State, to advance its interests as a body of citizens and a liberal profession, and to promote the advancement of medical, surgical, and hygienic science." This embraces the whole comprehensive mission of the Society. We are not an insurance association, nor is it the function of the Society to provide for its sick or disabled members; we have no expensive headquarters to maintain, nor any use for them; there is, in fact, no object within the scope of our Constitution to which an accumulation of funds could be legitimately devoted, and yet we have now in our treasury, according to our last report, an accumulated surplus of, in round numbers, $3,000. Now, our ordinary running expenses would not be materially increased if our membership were enlarged to 1,000; and if, with this proposed reduction in the annual dues, our membership should increase to even double the present, there would still continue the same or an increased surplusage from year to year.

Continuous Membership in the Local Society.

Second: I would propose a change in that portion of our organic law which requires continuous membership in a local society as a qualification for membership in this, by striking out that clause from Section 5, Article II. This has been a popular clause and I am free to admit that there is much force in many of the arguments in favor of its retention; but I am equally convinced that its effect is to keep many good men out of this Society. It is unfortunately true that doctors, like other mortals, will differ; they will even at times quarrel and hate each other with an intensity sufficient to produce indigestion in an otherwise healthy organization. It is too often the case that two, three, five, or more medical men meet and organize a local society; they may be the best or the second best men in the particular locality, they may not be either; but, through local differences, the fact of their membership and control of the local society prevents other good men, equally available both as to their character and talents, and with whom we might all be pleased and proud to associate ourselves, from obtaining or even seeking membership.

The smaller the territory embraced by the local society, the greater is the danger of this practically compulsory exclusion from the benefits of our State organization; for I think there are few of us who do not know of localities in this State where the personal differences between medical gentlemen, equally distinguished in their profession —differences which suggest no reflection on the character or ability of either party—are so strong that in cases where consultation is found necessary, assistance from outside the particular district has to be called in. By this I intend no reflection on the profession in the interior of our State—we have the same differences in our larger cities, but there the local organizations are naturally so much stronger numerically that membership in them does not mean intimate association with some one with whom we may be personally at variance; and this also applies with equal force to membership in this State organization. If the clause referred to were stricken from our Constitution, it is possible that many estimable gentlemen whom we are now unable to admit to membership for the reasons to which I have alluded, would be brought together under one banner, and it is even to be hoped—certainly it is by no means improbable—that under the benign influence of this organization, professional and social, some of these differences might be healed, redounding to the good of all. We would be no longer denied the fellowship of many worthy men in our profession, while they in turn would enjoy the benefits of membership in this Society.

A Quarterly Bulletin.

Third: I would recommend the publication of a quarterly bulletin, containing such information and contributions as the Committee on Publication might deem most worthy of space. By this simple measure, which is not an untried one elsewhere, we would bring our membership into relationship at least four times a year, and afford a vehicle for the interchange of new thoughts suggested by interesting cases which occur in even the most limited practice. Thus, too, we would furnish our members with something in return for their annual dues beyond the privilege of assembling once a year and of receiving annually a copy of our transactions and proceedings, while at the same time it would be a reminder to our members of the advantages of continuing their membership.

There is a principle active in the integral parts of this great Yankee nation which prompts us all to look toward getting the greatest possible return from every outlay. Let us, therefore, instead of accumulating a surplus for which we, as a Society, have no use, make the cost of membership less while increasing its advantages; and I think the natural result ought to, and will be, larger membership and greater interest in our work, both scientific and social. This accomplished, our Society may justly lay claim to the importance its name implies.

It is not with an ambition to pose as a reformer or a destroyer of an established order of things that I call your attention to this matter, but with a simple desire to actuate the motive which governs us all, the promotion of the interests and welfare of this Society and of the profession throughout the State.

Overcrowding in the Profession.

As before stated, in this State we have about 2,700 practitioners of medicine and surgery, graduates of regular medicine and licentiates of its Board of Examiners, without counting several hundred licentiates of homeopathy and eclecticism. This vast number has as a field of labor a State with a population of 1,500,000, which by a simple process of division shows one doctor to every 500 of population. To say that our profession is overcrowded expresses a fact too patent to admit of discussion.

As an equal distribution leaves only this small ratio for a clientele, what must be the portion left to some of the profession, when we find leading physicians who enjoy the patronage of thousands? The obvious tendency of this overcrowding, it is to be feared, is to lower the standard of professional conduct among regularly educated and licensed practitioners.

We have also to consider, in addition to this unpleasant picture of a small army of medical men striving for existence in a limited field, a host of quacks of various kinds and degrees, who, like the camp-followers that hung about Sherman's army on its famous "march to the sea," are ever on the alert to pick up choice bits of forage and sustenance that should fall to the lot of the regular soldier, whose mess must suffer to the extent of the irregular depredations. Here we have a somewhat homely, but, I think, pertinent illustration of the situation.

But it is easier to depict this unfortunate condition of affairs than to recommend measures of adequate relief. The following suggestions, however, seem to me to be appropriate: We should no longer hold out to intending students of medicine alluring pictures of the excellence of this State as a field for practice. Until the time comes, if ever, when there shall be a more reasonable proportion between practitioners and patients, it is bound to be a question of the survival of the fittest, and meanwhile, only moderate encouragement should be given to students, and to those only who, by more than average ability, and by a high degree of preliminary education, give promise that at the end of their course of medical study they will come into the field fully equipped and qualified to engage in what, at best, must be a struggle for existence.

Again, it is well known that medical men cannot go from this to other countries on the American continent or in Europe and assume the practice of medicine until after a strict examination there, and the securing of a certificate in accordance with the laws of the government under which they may choose to settle.. We, however, with that excess of liberality found only in this land of refuge for all people, and of the refuse of many, the "Heathen Chinee" not excepted, receive all comers with open arms, welcome them to share our meager loaf, and our people patronize them to the exclusion, frequently, of those to the manor born, and at least equally qualified by natural ability and education. The halo of mystery and greatness which hovers about a foreign doctor seems to have a peculiar fascination for the American mind, and our imported frater is not always too modest to use this peculiar bent for all the advantage it may bring him.

Hospital Clinics and Free Dispensaries.

The influence of hospitals, dispensaries, college clinics, etc., upon the general practice, has been considerably discussed of late. That the increase of such institutions is having a marked effect upon the field of labor of the general practitioner, especially in metropolitan centers, needs no argument. That the best service in all branches of practice is freely given in the several free dispensaries or clinics in San Francisco, while the excellent hospitals offer to the afflicted at small cost, a haven where capital operations are performed daily by skilled operators under the advantageous surroundings of the most modern methods, and that the tendency of all this is to diminish the field for work for the less favored who constitute the larger portion of the profession, is also an accepted fact.

The young man entering the profession, however well fitted by thorough training, supplemented by hospital experience in the best institutions in the world, finds but a limited scope for his talents, if he be not one of the fortunate few holding positions in public or private institutions that bring to them abundance of material for the exercise of their acquired skill. He must content himself with sitting patiently in his office, waiting for business that is long in coming or that may never come. The claim that suffering humanity alone should be considered in a question like this—that better service can be rendered in hospitals under aseptic conditions—is no doubt to a certain extent just, and the general practitioner, recognizing this and frequently ready to sacrifice his own interests to that of his patient, is often quite ready to recommend a sufferer to the hospital. He even goes there himself, and, with his hands in his pockets, or behind him (as a precaution against the conveyance of germs from his polluted person) watches his more fortunate brother, made clean by aseptic ablutions and bedecked in a clean apron, do his work. Then he goes away filled with a satisfying consciousness of having served his patient well, but with an empty pocketbook and a lack of that practical experience which properly belongs to him. He is little benefited even by observing the operation; it is one that he has probably seen and taken part in many times before.

The practice thus outlined may be best for humanity, but it results in making experts of one class, while the great mass of medical men are dropping into mediocrity and losing the incentive to improve their acquired ability for lack of opportunity to exercise it. In the rapid growth of this dispensary system, our medical men are themselves the most active agents. I speak only of dispensaries under the management of regular practitioners, such as college clinics, dispensaries, etc., under the auspices of colleges or associations, conducted in the name of charity, sweet charity, under whose banner skilled services, medical and surgical, are free as water. Various means of advertising, all strictly legitimate, are resorted to to encourage the afflicted to seek professional aid in these free centers of practice, while around the corner—many corners—are seated in their offices well skilled medical men waiting in vain for their fair share of business, which, if an equal division could be made, would leave them a clientele of less than 600.

If all who availed themselves of this gratuitous system of service were really entitled to it, there would be less cause for complaint, but it is well known that many who can well afford to employ a general practitioner, now resort to these institutions whose real object is, or should be, to dispense medical and surgical aid to the poor and needy.

It is well occasionally to get down from the high plane from which this subject is frequently treated. Medical men are prone to soar to a high level. We speak of our remuneration as an "honorarium," yet after all we are only a class of breadwinners in common with others of our fellow beings—an honorable class—striving to earn a livelihood by the pursuit of our profession. The practice of medicine is our business; and most of us are, or ought to be, supporting and educating families out of the legitimate financial proceeds of our business. If we could all become suddenly alive to this important fact, and could at once proceed like a band of brothers to a fair and equitable distribution of work and its proceeds, then indeed, should we see a medical millenium; but this is, of course, a chimera not possible to Code. No medical body, much less an individual, is likely to change the trend of current events. Some good, however, may be attained by directing our attention, for a moment, to these problems, and to their bearing upon the welfare of the medical world.

Feticide.

Feticide, infanticide, and methods of preventing pregnancy, are subjects tabooed in polite society, and even in a body of medical men they generally receive little or no attention. The evil, however, is becoming one of such magnitude, so far reaching in its effects, that I feel it incumbent upon me, as the temporary exponent of this Society, to give free and bold expression to the abhorrence in which all reputable practitioners must hold the various methods of prevention of child-bearing, and the very frequent procurement of abortions, as tending to deteriorate the moral tone of society, debauch public sentiment and shake the foundations of society—the domestic relation, the home. That regular medical men and women, such as constitute my hearers, do not participate in these disreputable practices, is a position I desire in the strongest manner possible to maintain, but that in the popular mind we escape the odium attached to them, is, unfortunately, not susceptible of proof. It is too true that the upright regular practitioner shares with the charlatan or advertising quack whatever popular opprobrium these nefarious secret practices receive. With the great public a "doctor" is a doctor. Reputable medical men and women that indignantly dismiss a patient who applies to them for such a purpose, are frequently met with the remark, "Why, I thought all doctors did it." And so the few cases which are brought to public notice through the death of the unfortunate woman at the hands of some scoundrel, man or woman, calling himself or herself "doctor," bring odium on our profession, and usually without remonstrance on our part.

It is high time the regular profession should take a stand and clear its skirts of the opprobrium. It is our duty, both by precept and practice, to establish the fact in the minds of the public that we have no sympathy with criminal business, or with the criminals who practise it. When that point is attained we may reasonably hope for some abatement of the evil. It is a lamentable fact that a large proportion of the male population believes that this nefarious business is practised by almost all medical men, and while that popular impression prevails juries will not convict, even in flagrant cases. It has been demonstrated in recent trials in San Francisco that a man who has openly practised a criminal business for many years, who drags his unfortunate victim from his own infamous den and places her upon a car to die a few hours later in transportation, may go scot free.

The public prints are frequently filled with the nauseating details of some of these cases; many, we know, are hushed up, while the culprits are left unmolested to continue their unlawful practices. One solitary conviction stands out in bold relief, and this in the present perverted state of public sentiment seems somewhat of a shock. "Why should not this man have gone free when everybody is doing it?" asks many a good citizen; and, in fact, it is doubtful whether the conviction in that case was as much a mark of the jury's disapprobation of the crime committed on the living body, as it was of its horror of the barbarous mutilation of the senseless corpse.

The prevention of these unlawful practices is ultimately a matter for the people and for the Courts. The present law seems inadequate, and public sentiment does not seem to be strong enough to devise proper remedies. Does it not behoove us, therefore, to do what we may towards stemming this tide of immorality? The regular profession should take no unequivocal ground, but should, in season and out of season, contend against the continuance of these practices, and strive to educate the people to a higher plane of morality. If we do not do so, the fair escutcheon of our time-honored profession will continue to suffer the opprobrium brought upon it by the practices of a disreputable class with whom we have no connection by sympathy or association.

It should be the duty of the physician not only to frown down these practices, but also to use the greatest care, lest by a word or hint he carelessly direct an applicant for criminal relief to one of these dens of infamy. It will not do to say to an unfortunate suppliant that such and such persons have the reputation of doing these things; we cannot afford to become even indirectly agents, or "steerers," if I may use the term, for these people, simply as an easy method of getting rid of an undesirable patron. No; the proper thing to do is to answer these deluded women in a manner short and sharp, "We have nothing to do with such cases, and do not know of anyone who practises criminal business."

The statutes in reference to evidence in cases of criminal abortion should be modified, so that evidence of the only other witness to the crime beside the operator might be available to prove guilt.

Embalming.

The disposition of the bodies of the dead, owing to the growing sentiment in favor of cremation, occupies a prominent place in the minds of the medical profession. For sanitary reasons the profession is almost a unit in favor of incineration. One objection to this plan for disposing of the dead, however, from a medico-legal point of view, is that by it all evidence of the cause of death disappears, if we may be allowed the expression, in smoke.

While speaking on this point, it is pertinent to refer to a custom which is becoming established among undertakers, and which should be stopped. I refer to the injection of the body immediately after death with embalming or preservative fluids, a proceeding in this climate wholly unnecessary. It is a trick that is being too successfully worked by undertakers, for their own profit, on the friends of the deceased. Thoughts of economy, much less of parsimony, seldom enter the minds of the grief-stricken family, and so when the shrewd undertaker, with thoughts of his coming bill, suggests, "Of course you wish the body embalmed?" the answer is rarely in the negative. But I refer to the matter for the more important reason that the corpse, after being subjected to this so-called embalming process, is saturated with mineral poison, obliterating every evidence of crime, if any exists. I recommend that the Committee on Legislation endeavor to have a law passed prohibiting the use of any embalming process until after permission has been granted by a coroner, or other proper officer.

The Code of Ethics of the American Medical Association.

The Code of Medical Ethics adopted by the American Medical Association and by the Medical Society of the State of California, has been the Magna Charta of the profession throughout the United States for many years, and has seemed ample for the purpose for which it was designed—the regulation of the conduct of members of the profession. However, the development of specialties and the overweaning desire of some of the leading medical men in New York city to enlarge the scope of their practice, has of late caused a departure from some of our long established principles, and the adoption of a modified Code in the State of New York.

At a recent meeting of the American Medical Association a committee was appointed to revise the Code, and the matter will undoubtedly be brought up at the meeting to be held this year in San Francisco. I do not propose to attempt to influence the action of members of this Society in the matter, but I urge you all to study the Code thoroughly, and if, after mature reflection, that Code, which has stood the test of time, meets your approbation, I would be glad to see the profession in California loyal to its tenets. The medical profession in the United States has done well under the present Code of Ethics; its history is one upon which we can reflect with pride. Under this Code ample scope has been allowed for the progressive members to make brilliant records by the introduction of new methods in the practice of medicine and surgery, which have redounded to the credit of the medical world. The minority report of the committee before referred to, reporting against changing any part of the Code, meets my hearty concurrence. It reads as follows:

Minority Report.—The minority of the Committee on Revision has the honor to report against any kind of revision of the Ethical Code:

1. Because the language of the Code is clear, concise, and accurate, and conveys to the mind the soundest ethical principles derived from the moral maxims of all civilized nations, compiled and admirably arranged by practical men of acknowledged ability and wisdom.

2. Because the Code is explicit, liberal, broad, humane, and founded on truth, justice, and reason, and is free from magisterial assumption or oppressive exaction.

3. Because the Code contains full particulars, without superfluous details, for the guidance of all physicians, for the instruction of beginners, and for the information of the people.

(Signed) HENRY D. DIDAMA.

Quarantine and Cholera

At the time of the twenty-third annual meeting of this Society in 1893, Asiatic cholera threatened to invade England and the United States. That we were not visited by the dreaded scourge is due to the enlightened and efficient measures adopted to arrest it; and although infected ships arrived off New York, the barriers proved effectual. The loss of human life, not to speak of the damage to the business interests of the country which an epidemic of Asiatic cholera would have caused, cannot be measured. Such an invasion would have demoralized all traffic, have paralyzed our commerce, and have proved the utter ruin of the great Columbian Exposition. The success attending the measures adopted to avert this disaster is the highest testimony to the efficacy and value of modern sanitary science.

A Roll of Deceased Members.

Death has entered our ranks during the past year, and taken some useful and honorable members from our roll. The names of some of those who have passed away are so familiar that it will hardly need the report of the committee on necrology to recall them to our memory. Respect for the dead is an attribute of the human mind in all classes, from the highest to the lowest, and from the earliest times in the history of the human race; the grief of the living has sought solace in efforts to perpetuate the memory of the virtues, the attainments and the achievements of those who have gone before. It seems to me that it would be an excellent thing to collate the names of all who have died, or may die in active membership in this Society, and to publish the list in our transactions every year, or at least every third year. Many of those who have been taken from us were, it is true, so distinguished in their lives that it needs no effort on our part to preserve them from oblivion; but even if this be so, let us perpetuate their names in our transactions, even though it be only for the more selfish reason that the record of their association with us will, for all time, make more prized the honor of membership in the Medical Society of the State of California.

ABSTRACT OF THE REPORT OF THE COMMITTEE ON CLINICAL MEDICINE

Of the Medical Society of the State of California.

By Albert Abrams, M.D., Chairman, San Francisco, Cal.

Physiological Pulmonary Atelectasis.

The speaker said: At a previous meeting of the Society he had presented a paper on "Pulmonary Atelectasis as a Cause of Anemia" (transactions of 1892). His observations had been extended since the publication of this paper, and the results attained confirmed his conclusions.

While it is true, from the standpoint of the pathologist, that the lungs, during life, are in a stretched condition, it is equally true, from the position of the clinician, that certain portions of the lung are collapsed and deprived of sufficient air to yield a dulness, or in some instances a flatness, on percussion. These areas of dulness vary in size, as determined by linear percussion, from a twenty-five cent piece to a dollar, or even more. The atelectatic zones are only permanently absent when the lungs are emphysematous, and temporarily so after repeated deep inspirations. I have noted in my investigations that, after forced inspirations are made, the atelectatic zones in adults, as well as in children, can be dispelled, reappearing in a few minutes when tranquil breathing is resumed, and continuing so until an increased demand is again made on the capacity of the lungs. The facts just enunciated do not refer to the areas of lung tissue intermediatory to the atelectatic zones, for we already know from the observations of others, especially Da Costa, that when percussion is made over the lungs by respiratory percussion, as it is called, that at the end of full inspiration, a sound of higher pitch and vesiculo-tympanitic quality is obtained; whereas a held expiration diminishes the resonance. [The speaker here gave diagrams illustrating the relation of the atelectatic zones, based on examinations of over 100 cases.]

The practical conclusions that can be formulated as a result of these observations, may be summarized as follows:

1. The relation that pulmonary atelectasis bears to anemia.
2. The mistakes that may occur from misinterpretation of the physical signs in examination of the chest, and the correction of the conventional errors of topographical percussion.
3. The relation that pulmonary atelectasis bears to tuberculosis.
4. The aid afforded to auscultation by the elimination of atelectasis.

1. I have already shown that anemia of pulmonary origin exists, and that this anemia is associated with extensive areas of lung dulness. That when the latter is corrected, amelioration and recovery from the anemia occurs. I have also referred to the fact, that increased respiratory activity is of great therapeutic value in anemia from any cause.

2. The mistakes that may accrue from misinterpretation of the physical signs of the atelectatic dulness, from dulness caused by lung consolidation are many, and in consequence of mistakes occurring in my own practice, and in the practice of other physicians, I invariably adopt the expedient of having the patient practise forced breathing before making an examination of the chest. If inflation of the lung cannot be secured with the patient in the erect posture, I place him in the right or left lateral posture, according to whether an examination of the left or right lung is desired. I have often found

that dulness produced by lung consolidation will frequently disappear to be supplanted by resonance after forced deep breathing. This tact may, to the novitiate in physical diagnosis, be mistaken for atelectatic dulness.

3. The relation that atelectasis bears to pulmonary tuberculosis is an important one. A properly inflated lung affords adequate protection against pulmonary tuberculosis. A collapsed area of lung tissue serves as a nidus for the specific microbes. The facultative anerobins thrive best in an illy ventilated lung. Pulmonary tuberculosis is frequently initiated by the symptomatic picture of anemia. This anemia is unquestionably of pulmonary origin and is associated with demonstrable atelectatic zones. The atelectatic zones correspond with the destructive routes followed by incipient pulmonary tuberculosis.

4. The aid afforded auscultation by elimination of atelectasis is obvious. Auscultation of the lungs should be conducted with the patient in different postures, the object being to utilize the actual respiratory capacity of the lungs, thus eliminating the auscultory phenomena of atelectasis and accentuating abnormal sounds which may be present. I have recourse to the following maneuver for eliciting pleural friction sounds when absent and accentuating them if present: Have the patient lie on the suspected side or region for half a minute or longer, after taking a deep inspiration. This position favors the approximation of the two pleural layers. When the patient adopts the sitting posture and attempts forced expiration, a friction sound is heard which is usually intensified during the subsequent inspiration.

Congelation in Diagnosis and Treatment.

To Prof. Debove is imputed the credit of having first demonstrated, in February, 1884, the therapeutic application of freezing, by means of chloride of methyl, in the treatment of neuralgia, although the speaker had suggested the application of rhigolene for the same purpose, in his inaugural dissertation in 1881. (*Therapeutic Memoranda.*) He now desired to report certain original investigations made with this therapeutic agent.

Freezing with chloride of methyl has been extensively employed for the treatment of various neuralgias, irrespective of the pathogenic diagnosis, as well as in rheumatism and other affections manifested by pain. Its efficacy in properly selected cases of neuralgia entitles it to enrollment among the specific agents in medicine. Only those accustomed to the employment of congelation in the treatment of neuralgia can appreciate its marvelous action in many intractable cases of this affection. He had never witnessed any untoward effects beyond slight cutaneous ulceration in an elderly individual treated for sciatica. The use of any therapeutic agent based on empiricism alone will yield clinical results wholly at variance with strict scientific inquiry. He had, therefore, endeavored by theory and experimentation to evolve the rationale of freezing as a therapeutic agent.

The following hypotheses were presented:

1. Freezing may act as a counter-irritant, and the results achieved may be due to local or reflex action.

2. Freezing may act by producing physical changes in the underlying structures.

3. It may act as a shock.

The first hypothesis may be contravened in part on the assumption that freezing, unlike counter-irritation, is immediate in its action, of greater potency, and followed by slighter reaction. The degree of cold secured by the usual methods of freezing is neither of sufficient intensity nor duration to warrant such a postulate. The reduction of temperature, as I have determined by experiment, is never sufficiently great to firmly sustain the first hypothesis. By *reënforced freezing* a reduction of temperature to the freezing point can be secured.

The second hypothesis may be disposed of by briefly citing the results of certain experiments. If the skin over the nerves of rabbits is frozen daily and the nerves afterward examined, no degenerative changes in the latter can be demonstrated, and it is only after freezing is carried to an inordinate degree and repetition, unlike its clinical application, that any degenerative nerve changes can be demonstrated.

The final hypothesis is the most probable, viz: that freezing acts as a shock, inhibiting the nerve functions for a variable period. While conductivity is an expression of physiological nerve activity, pain is an expression of pathological nerve activity. The inhibition of the activity of a pathological nerve expresses the ideal attainment of therapeusis. This is secured remotely by analgesic, or directly by local medication. In order to intensify the shock in freezing, I adopt one of the following modifications of the conventional methods of freezing: (1) Anemizing the part to be frozen by means of an Esmarch bandage. (2) Parenchymatous or hypodermic injections of water.

By means of the first modification, congelation occurs sooner, is more intense, and of longer duration.

The second modification, which I have denominated "reinforced freezing," and which can be employed in conjunction with the first modification, is executed as follows: With a large-barreled syringe, a sufficient quantity of water is injected beneath the skin over the part to be frozen, or directly into the tissues, until an appreciable bulging is produced. If the spray is now directed on the protuberant part, a lump of ice is formed in the tissues or under the skin.

I have employed congelation as a means of diagnosis for the following purposes:

1. To diagnose neuralgia of central from one of peripheral origin.
2. To differentiate neuritis from neuralgia.
3. To locate the lesion in neuralgia.
4. To differentiate many neuralgic affections of the head, and thoracic and abdominal parietes from visceral disease.

To differentiate between a neuralgia of central and one of peripheral origin is conceded to be a difficult matter. I believe, however, that by means of freezing we possess a valuable aid in diagnosis. If a nerve, the seat of neuralgia, is frozen nearest its point of origin, the pain will disappear if the neuralgia is of peripheral origin, and persist if of central origin. In the absence of spontaneous pain, the painful points in the course of the nerve distribution may serve as guides. Freezing is a specific for all recent forms of uncomplicated neuralgia. Cases in support of this theory were then given.

To differentiate neuritis from neuralgia: Neuralgia of an accessible nerve treated by freezing near its point of exit, failing to yield to repeated applications of the spray, is not a veritable neuralgia, but a neuritis or complicated neuralgia. The speaker said this statement was based in part on a carefully kept record for many years of numerous cases of occipital intercostal and sciatic neuralgias, reports of two of which were given.

In the treatment of neuralgia, when reinforced freezing is not advisable, recourse may be had to a modified method, which I have denominated "coin freezing." The method is as follows: A coin of varied size is employed, which, having been previously moistened in water, is placed in close contact with the site to be acted upon; the spray is next directed on the coin. After allowing the spray to act for a certain time, that is determined by experience, it will be found impossible to remove the coin without some difficulty. The advantages claimed for this method are: That the freezing is more thorough, and it can be accurately localized. It is less severe than reinforced freezing.

As a means of localizing pain: In evidence of this, two cases were cited. In one, a painful cicatrix amongst small scars, was differentiated. In another, trigeminal neuralgia was traced to a carious tooth. In a third, a neuroma was discovered.

To differentiate many neuralgic affections of the head and thoracic and abdominal parietes from visceral diseases: It is an indubitable fact to which detailed reference, to my knowledge, has never been made, that neuralgia of the intercostal nerves may be accompanied by visceral symptoms of such prominence that the intercostal neuralgia is overlooked, and treatment is directed toward a presumable visceral disease. Such cases, while presenting a varied clinical picture, are frequently analagous, if only atypically so, of gastric, cardiac, renal, vesical and esophageal affections. In many instances the symptoms of intercostal neuralgia in the implicated nerves corresponding to the presumably involved viscus are either absent or incompletely pronounced. As a rule, however, vertebral tenderness corresponding to the exit of the nerves can be elicited, and when congelation is conducted over the seat of vertebral tenderness during a paroxysm, the latter is nearly always inhibited. In support of this position several cases were cited.

In conclusion, the speaker said that freezing was not advanced as a catholicon, but as an efficient therapeutic and diagnostic agent in many properly selected cases. Its use may be extended in surgery in the treatment of local tuberculosis, tumors, etc. Parenchymatous injections of water into tumors, coupled with freezing (reinforced freezing), may prove of inestimable value in the treatment of neoplasms. In parasitic affections of the skin he had met with marvelous results in some cases.

ABSTRACT OF THE REPORT OF THE COMMITTEE ON OBSTETRICS

Of the Medical Society of the State of California, April, 1894.

By H. H. HART, M.D., Chairman, San Francisco, Cal.

Management of the Third Stage of Labor.

The speaker said he had selected as his subject one that was of great importance to the attendant and to the patient—the management of the third stage of labor.

The different methods of treatment in this stage are divided into passive and active; the latter again being subdivided into indirectly active methods—as coughing, sneezing, bearing down, and straining; those directly active upon the uterus; and finally, those directly active upon the placenta.

The passive method was largely employed at the beginning of the nineteenth century, but was supplanted by manual extraction. It was about the middle of the present century in England and Ireland that the placenta was delivered by means of external pressure, which method was introduced by Credé, in 1861, into German lying-in institutions. About 12 years ago at the clinics the passive method was advocated and adopted. This allowed greater scope to the natural forces, but in private practice the obstetrician resorts to active measures, delivering the placenta from a quarter to a half an hour after the birth of the child.

All of these methods were employed by the most ancient races, and are still by our savages of the present time. It has also been asserted that from the most ancient times to the beginning of the sixteenth century there was no treatment of the third stage of labor. The speaker said we had not advanced much beyond the ancients, and mentioned the customs prevailing amongst the different savage and semi-civilized nations.

The third stage of labor is no doubt the most important epoch of parturition, wherein the intelligent and skilful management is of paramount importance. At the same time, it is the period where most errors are made. By proper care during this time *post-partum* hemorrhage and septic infection are reduced to a minimum, effective contraction of the uterus is obtained, the intensity of after-pains lessened, and the safety and comfort of the patient considerably enhanced.

Many German writers, as Winkle, Fruend, Dohrn, Ahlfeld, and others advocate the expectant plan for the expulsion of the afterbirth, claiming that as the force was sufficient to expel the child, in spite of the resistance of the pelvis, it is also capable of ejecting the less resisting placenta without the aid of the hands.

Playfair, advocates the expulsion of the placenta by a *vis a tergo;* and he states that the uterus itself must be made to expel the placenta, and that no force should be used from the front. He also says that it is not even necessary, in the majority of cases, to touch the cord, or even put the fingers into the vagina after the birth of the child.

To this latter I must take some exception, as I have had considerable obstetrical experience; and I am fully justified in saying that very slight traction upon the cord, and even hooking a finger into the edge of the placenta, when it lies in the vagina, facilitates the expulsion of the afterbirth; I do not mean forcible traction, but slight traction to aid the force from above.

The pressure upon the uterus through the abdomen after the delivery of the child has been recommended by many German writers as a preventive of *post-partum* hemorrhage, "but the distinct enunciatian of the doctrine that the placenta should be pressed, and not drawn out of the uterus, we owe to Credé and other German writers, and it is only of late years that this practice has become at all common."

Some modification of Credé's method may with advantage be made. Credé delivered the placenta usually within five minutes after the birth of the child. This rapid expression is no doubt dangerous in favoring hemorrhage, as the placenta is not usually detached at the inception of the third stage; and until it is detached expression is injurious.

Forcible traction must at all times be deprecated, as it will in many cases cause the medical attendant much trouble and anxiety. He had known several instances where this had almost caused the death of the patient; and he referred to one case of very serious hemorrhage occurring five days after delivery, and due to the retention of a small fragment of placenta.

Too great haste and force used in expressing the placenta, so as to propel it out of the uterus, through the vagina, and upon the bed, exposes the patient to another serious danger. The weight of the mass may be sufficient to tear off and leave behind portions of the membranes that could easily be removed by gentler methods.

So long as we are satisfied that the uterus is fairly contracted, so as to avoid the possibility of its distension with blood, a certain delay after the birth of the child is requisite; from its giving sufficient time for the coagula to form within the uterine sinuses, by which their open mouths are closed up.

Fifteen to thirty minutes should elapse before any attempt is made to remove the afterbirth, This is a good, safe and practical rule, as it gives ample time, in the majority of cases, for the placenta to become completely detached from the uterus and for the coagulation of the blood in the uterine sinuses.

The uterus must not be kept hard and firmly contracted; alternating contraction and relaxation is what is required to separate the placenta.

When we are fully satisfied that sufficient time has elapsed, we can proceed to effect expulsion in the following manner: After one or two pains have occurred, the fundus should be grasped in the hollow of the left hand, the ulnar edge of the hand being well pressed down behind the fundus, and when the uterus is felt to harden, moderate and firm pressure should be made downward and backward in the axis of the pelvic brim. The uterus must not be crowded down into the pelvis. In nearly every instance the placenta can be felt to slip down from its attachment, and a sudden and decided change in the size and shape of the uterus is detected. At this time make slight and gentle traction on the cord, or, if necessary, hook your aseptic finger into the lower part of the placenta, which will be found in the vagina.

Adherent placenta is rare, but I have had several cases in my practice which have required artificial detachment and removal.

The operation for the removal of adherent placenta is a delicate and a serious one, and even with the greatest care on the part of the physician, the risk to the patient is great. It exposes her to the danger of injury to the uterine structures and the leaving behind of portions of placental tissue, which may give rise to secondary hemorrhage and septicemia.

Anesthesia may not be necessary in all cases. Supporting the fundus of the uterus with one hand, guide the other carefully to the site of the placenta by means of the cord. Then gently introduce the fingers between the lower edge of the placenta and the uterine wall, and carefully peel off the former. Care must be taken not to injure the uterus, as it is not an easy task to distinguish it from the placenta. In cases of this kind I always resort to antiseptic intrauterine injections after delivery.

In the management of the membranes, care should be taken that none of them should be torn off and retained *in utero*. When the mass of the placenta is expelled, the membranes generally still remain in the vagina, and even within the uterine cavity. They should be twisted into a rope, and very gently withdrawn, during the interval of relaxation of the uterus.

The accoucheur should at all times satisfy himself as to the integrity of the placenta and membranes. The placenta should be spread out, its smoothness and gradual flattening toward its circumference, the relations of the cotyledons to one another, and also the location and size of the tear in the membranes noted. Should any part be missing, search for the same should be made at once, among the blood clots, in the vagina, and, if necessary, in the uterine cavity.

When we are satisfied that the uterus is firmly contracted, the binder can be applied, but this should rarely be done until at least a half hour after completion of delivery. The utility of careful bandaging after delivery can scarcely be doubted, although many physicians discard it. But it gives comfortable support to the lax abdominal walls, diminishes the sensation of emptiness, keeps up a certain pressure on the uterus, and tends to restore the figure of the patient.

In every case of confinement, it is advisable to examine the perineum. This can readily be done at the time of the expulsion of the placenta. If found lacerated, the parts should be carefully trimmed and adjusted, and the necessary sutures applied. The perineum, from the great pressure it is subjected to, is not very sensitive, and can be sutured, if lacerated, without much pain. By doing this at once, we save the patient much suffering in the future, and a neglect of the same is the most frequent cause of prolapse of the vagina and uterus.

In concluding, the speaker said great suffering and even death, in many instances, can be averted by strict observance of asepsis in midwifery. Frequent examinations should be condemned. The hands of the accoucheur should always be asepticized. They should at all times be surgically clean when making his vaginal examinations, particularly in the third stage of labor, for at this time there are abrasions, and usually one or more lacerations, of the mucous membrane, frequently extending into the deeper tissues.

Before making an examination the hands should be washed with soap and water, not forgetting to use the nail brush thoroughly, and then held in a solution of bichloride of mercury to insure an aseptic condition. Before labor, the external genitals should be washed with soap and water, and then with a solution of bichloride of mercury, one in two or three thousand, and thoroughly dried.

As we desire to save the mucus, the natural lubricating secretion which nature so wisely provides, he did not advise the use of the *ante-partum* douche, unless we suspect gonorrhea or leucorrhea. For this we can use a douche of a quart of warm water containing an ounce of the liquæ sodæ chlorinatæ or the bichloride solution of one to three or four thousand.

Regarding the *post-partum* douche, he was in favor of this in cases of protracted labor, where operative interference wae necessary, and where the secretions are purulent. He used either a solution of liquor sodæ chlorinatæ, one ounce to the quart of water, or two drachms of carbolic acid to the same quantity.

ABSTRACT OF THE REPORT OF THE COMMITTEE ON GYNECOLOGY

Of the Medical Society of the State of California, April, 1894.

By W. H. MAYS, M. D., Chairman, San Francisco, Cal.

The Curette; Its Indications and Dangers.

The speaker said: The operation of curettage required as strict an observance of the *technique* of antisepsis as a laparotomy. The vulva is scrubbed with soap and brush, and the vagina irrigated with a bichloride solution. Sterilized towels are placed around the vulva, and operator, assistants, nurses, and instruments are subjected to the usual aseptic precautions. After emptying the bladder, the patient is placed in the lithotomy position, the Sims or Simon speculum applied, and the anterior lip pulled forward with a vulsellum. In applying traction to the uterus, great caution should be exercised, particularly where inflammatory changes have taken place in the adnexa.

Dilatation or divulsion of the canal is not always demanded, as for instance in puerperal disease. The steel dilator with thick corrugated blades, is the best and safest instrument. Thinner blades are more liable to lacerate. Where much contraction is present, a finer instrument, or even a pair of uterine dressing forceps may be used at first. Open the blades slowly, and by manual pressure alone. The screw should be used with the utmost caution, if at all, for it exerts an amount of power that cannot always be measured by the operator. He was convinced that a considerable proportion of the disasters that follow curettage are due to too rapid divulsion. Our obstetric experience should tell us that uterine muscle yields slowly and with reluctance, and if stretched suddenly will tear. First open the handles laterally, then relax and shift their position and stretch again, thus gradually working the instrument around until the dilating force has been evenly exerted upon the whole circumference of the cervix.

With the sound, the direction and length of the canal is now ascertained, the curette is pressed to the fundus, and the endometrium scraped systematically; commencing at one cornu, and working round to the place of beginning. A grating of the tissue under the instrument is sometimes felt by the operator, and even heard by the assistants. This sensation is not imparted in every case, and must not always be expected. To lay down the rule that curettage is incomplete without it, would be a grievous mistake. The muscular tissue may, in certain septic conditions, be so softened and degenerated that the operator, in search of the grating sensation, would be likely to achieve a perforation instead.

The next step is irrigation of the uterine cavity with hot water. This is best done with a reflow irrigator. The tubal orifices may be relaxed, and the stream of water may enter the abdominal cavity if propelled with much force, or if the outlet be blocked up with a large nozzle. Swabbing the cavity with iodine tincture after curetting interferes with good drainage. It is an astringent, and upon its use the organ contracts, so that gauze packing can only be imperfectly done.

For packing, take a strip of iodoform gauze an inch and a half wide and one or two yards long, and pack it lightly up to the fundus, leaving the end hanging from the os. Leave this *in situ* not less than 48 hours. If removed sooner than the second day, it has to be torn away from its adhesions, often causing fresh bleeding and increasing the traumatism. After the second day it will have become coated smoothly with lymph and slips easily out of its bed. After removing the gauze, a vaginal douche must not be given for eight or ten hours. A week or ten days in bed must be insisted on in every case.

Curettes of various designs are to be found, but they may be reduced to two varieties, the sharp curette with inflexible shank, and the dull curette with flexible shank. Baldy, in the American Text-book of Gynecology, pronounces in favor of the sharp instrument for all but exploratory work. Pryor, of New York, lauds the sharp curette as by far the best. Many will venture to disagree with these gentlemen, and hold, with the speaker, that the dull curette of Thomas is the safest for general use. There are cases which call for the sharp instrument, and without it no surgeon's equipment is complete. But it is surprising how thoroughly the womb can be scraped with the milder instrument, how much securer the surgeon feels in handling it, and how much more benign are its after-effects in comparison. We ought not to consider the curette as a knife; its end and aim is to scrape and not to cut. The flexibility of the shank is a decided advantage, but it should not bend too easily. A moderately small blade will prove most serviceable, and will require less dilatation for its admittance.

The indications for the curette are numerous and varied, and it is constantly supplanting older methods of treatment. Formerly there was held to be one main indication, namely, pathological uterine hemorrhage, and in many conditions, the curette is the hemostatic *par excellence*, checking the flow and effecting a symptomatic, if not a radical, cure. There are many other conditions besides those in which hemorrhage is a leading feature, where the usefulness of the curette has been prominently brought forward of late. The following is a brief consideration of the principal ones:

Puerperal endometritis: Much had been said lately for and against curettage in puerperal endometritis. But the speaker was convinced that many a life would be saved if it were resorted to more promptly and unflinchingly in this formidable disease. The following were the objections offered: (1) The procedure is highly dangerous. (2) The affection is systemic, resulting from absorption of toxines, and the curette cannot reach it. (3) The endometrium is, in most cases, only secondarily affected. (4) Admitting that the endometrium is primarily affected, the infection spreads so rapidly beyond the mucosa that the only result is to inflict further lesion for the introduction of sepsis.

These objections are largely theoretical. Results prove emphatically that the curette does reach the disease and exercises a profound influence upon it. Nothing is so dangerous as non-interference. The magnificent achievements of Weiss and others with the curette in puerperal sepsis mark a new era in our treatment of this disease.

Chronic endometritis: The curette treatment of obstinate endometritis is one of the most promising of the recent steps in gynecological advancement. It offers a rational method for the relief of that large class of uterine patients that come under the head of "office cases." In these cases of catarrhal endometritis of cervix or corpus, a more satisfactory result will be reached by a careful aseptic curettage, followed by the gauze tampon, than by the routine practice of intrauterine applications. The procedure may have to be repeated, but even one curettage will often work a radical change for the better.

Salpingitis: In acute tubal disease, the teachings of Pryor, Krug, Baldy and others, as to the value of curettage, may be accepted as generally true. A salpingitis is always an extension of an endometritis; and, on the other hand, an endometritis may be kept alive, or constantly relighted, by a discharge from a diseased tube. Treat vigorously the endometritis by scraping and repeated packing, and a marked effect is produced upon the salpingitis. It is especially in the early stages of tubal disease that the benefit of curettage is most apparent.

Pelvic peritonitis: To curette the womb for the relief of pelvic peritonitis is a procedure that has recently found earnest advocates among advanced gynecologists. On pathological grounds there is much to be said in its favor, for pelvic peritonitis is always of septic origin. As in tubal disease, so in pelvic inflammation, the source of infection is the endometrium; the infective material either traveling upward along the fallopian tube, or, taking the less direct route, by way of the lymphatics. Those who, in cases seen early, before the inflammation has advanced, at once remove the source of infection, the septic endometrium, claim that the results fully justify the procedure.

Chronic metritis: In this rebellious affection, it is seldom that the symptoms are not ameliorated by the judicious use of the curette, which may be frequently repeated with impunity and with benefit.

A few words on the dangers and contraindications of the curette. It would be useless to deny that untoward results are constantly following its use. A seemingly careful and gentle application of the instrument has been known to again and again light up a violent inflammation. Why should so rational an instrument be so fertile in the production of pelvic disease? Neglect of post-operative and ante-operative antiseptic minutiæ is a more prolific source of failure than any other cause.

Delicacy of touch is another prerequisite. As a rule, the curette is wielded too vigorously. It is easy to scrape a hole through the womb in certain conditions of the organ, and we never can be fully positive that those conditions are not present. Perforation of the uterine wall is an accident that might be supposed to be due to rough or incautious use of the curette, but it is not always so. Dr. Edebohls reported a case at the November meeting of the New York Obstetrical Society. He was scraping the interior; the instrument passed, without appreciable resistance, through the soft posterior wall of the corpus, and entered the free peritoneal cavity. The uterus was removed at once by laparotomy, and the fact of perforation verified. Dr. Coe mentions a case in which the dull curette was used to remove placental tissue, and on withdrawing the instrument a loop of intestine came with it. Laparotomy was promptly done, and the opening in the uterine wall sutured. A patient, a month after delivery, called at the office of Dr. Tuttle, of New York. Finding evidences of retained placental fragments, he put her on the table and proceeded to curette. He felt something give way, and the curette passed through the uterine wall. Subsequently laparotomy was performed; a hole was found in the posterior wall of the uterine corpus, and the pelvic cavity was filled with blood.

Fewer accidents would occur if more gentleness were observed both in dilating and scraping, and if more precision in the knowledge of intrapelvic conditions were first arrived at; in short, if the instrument were resorted to in a less routine manner.

ABSTRACT OF THE REPORT OF THE COMMITTEE ON DISEASES OF THE MIND AND NERVOUS SYSTEM

Of the Medical Society of the State of California, April, 1894.

By W. S. Whitwell, M.D., Chairman, San Mateo, Cal.

The Commitment of the Insane.

The speaker said: There is a prevalent idea existing in the world to-day that within the walls of insane asylums are many persons who do not belong there, and that such persons might be liberated were it not for the injustice of certain interested parties, aided by physicians in charge of such asylums.

This opinion it is necessary to combat continually, and it matters not how successfully it may on one occasion be dealt with, it is sure to appear again and again, and to falsely excite the tender feelings of both the ignorant and the educated.

That any sane person can to-day become an inmate of any public asylum is beyond the bounds of possibility. The nearest approach to such a condition of affairs is that a patient may now and then be committed from a mistaken diagnosis. But is he in such a case likely to remain in the asylum very long? Surely not. And yet through the well-meant interference of outside persons injustice is done to those in charge of our asylums, and much needless pain given relatives and friends.

If a medical man of experience states the person in question to be insane, and another physician states he is not, the chances are fully nine in ten that the man is insane. If a layman makes the same statement regarding the patient's sanity in opposition to a contrary medical opinion, there is not one chance in one hundred that he is correct. The physician who declares a man insane presumably has good reasons for his belief; those who express a contrary opinion on the same case have merely failed to discover these reasons. A true conclusion in many cases can only be attained by repeated examinations, and a careful perusal of the history of the case.

When any respectable physician, with a moderate amount of experience in cases of mental disease, states that a patient he has observed for months is insane, he should be believed in preference to those who have not had the advantage of such observation. His opinion should not be ignored until the patient has not only jeopardized his own life, but often that of others. By taking too great care not to commit the sane, the needed protection which should be granted the mentally diseased is withheld.

In 1889, in New York, the Legislature created a State Commission of Lunacy which, in its reports, has given much useful information. Concerning the supposed fraudulent commitment of the insane, the Commission says: "While the Commission has found numerous instances in which the commitment papers were defective, it has yet to find any instance in which a sane person has been incarcerated within an asylum, or where the certificate of lunacy was obtained through fraud or any wrongful intent." The number of insane in New York in the care of the State approximate 16,000.

Dr. Stephen Smith, who was formerly State Commissioner of Lunacy, says, in a recent article: "There is also prevalent in every community an idea that the insane have certain personal rights, which are liable to be taken from them in the act of commitment and during custody. It is suspected that they may not be insane and are spirited away to an asylum for some sinister purpose, such as to obtain property, to prevent the revelation of crimes of others, of which they alone are cognizant, etc. The idea has its origin in the imagination of insane persons who have been confined in asylums. The examination during six years of ten or fifteen thousand insane in custody in the State of New York did not discover a single case of commitment or detention for the purpose of defrauding the insane, or of depriving them of their rights to their harm, and in the interests simply of other parties. And yet, during that period I investigated hundreds of cases of alleged conspiracy against the inmates of asylums."

Such would be the testimony all over the United States, and I doubt if a single case of fraudulent commitment and undue detention could be discovered.

The commitment of a sane man may, at first glance, appear an easy matter; but it requires the connivance in the fraud of the judge, the examining physician, and of the superintendent of the asylum and of his staff—a most unlikely possibility.

In making laws of commitment, while the possibility of abuse should be considered, the rights of the helpless insane, though most important, are very likely to be forgotten. It is most unjust that in the law the insane person is treated not as a patient, but rather as a felon and criminal.

The first section of the California law on commitment of insane persons reads, in short, as follows: "Wherever it appears that the person is disordered in his mind, the magistrate must issue a warrant directing that such a person be *arrested* and brought before a judge for examination."

He is not taken to a hospital and cared for by medical men, but is arrested and taken to court. By arrest and by being brought to court, the idea is conveyed to the sick man that he is to be tried for some criminal offense. At the very start he is led to believe that he is being unjustly treated, for if any crime has been committed he is positive that it is against himself.

This false idea is further fostered by his *trial* taking place in open court. He is taken before a mixed audience, anyone being admitted; reporters crowd about him and listen to inquiries into his private affairs and his home life, and while all his mental failings are laid bare they listen in hopes of being able to produce a sensational article in the morning's paper. Is this decent? Is it fair to the sick, in a helpless condition, to be thus questioned in public? Would such public questioning be allowed in any other form of disease? And why is it done! As a supposed, but utterly unnecessary, safeguard against the very remote chance that sane men may be unlawfully imprisoned.

It would be cruel to force a delirious typhoid fever patient through such an ordeal as this. Why is it any less of an abomination to bring into court from her bed of sickness a puerperal melancholiac, thereby endangering her mental and physical condition, and there discuss her private life as though she were a criminal?

The California law is unjust to the insane, for it leaves the commitment in the hands of the judge and not, as it should be, entirely at the discretion of the medical profession.

Two physicians of experience make the examination and satisfy themselves that the person is insane. The judge is called, comes to an opposite conclusion, and refuses to commit him. The man is set free and may, in consequence, as was actually the fact in one case, commit suicide within a few hours.

Is this right or just? Should not the insane have the advantage of medical skill and be protected from the results of non-medical opinions? Would it be any more ridiculous if a judge were called to decide what should be done with a smallpox patient?

The most satisfactory commitment laws are those which leave the whole responsibility of the commitment with the medical profession. From such commitments no evil has resulted, and, on the contrary, much good.

As an instance of this, let us consider for a moment the law of Arkansas. In that State any one can go before a judge and make an affidavit that, in his opinion, a certain person is insane. The judge may question him as to his reasons, and, after swearing him as to the truth of his affidavit, an order is issued for examination of the alleged insane by a competent physician. The family may then, if they desire, call another, who examines the patient independently and alone. If they agree, the patient is then and there committed. If they disagree, a third is called, and the majority rule. If the family do not call their physician, the first one called is empowered to commit, and the judge is obliged to sign such commitment. He has no option in the matter, and he is not asked for his opinion. Quickly, without undue publicity, and humanely, the commitment is thus obtained.

Fault must be found with another point in the California law, and this is in regard to the transportation of the insane. The law reads: "The insane person, together with the order of the judge and certificates, must be delivered to the sheriff of the county, and by him must be delivered to the officer in charge of the insane asylum."

Mark you! no provision is made by this section of the law for the accompaniment of female patients by any one except the sheriff. It is hardly necessary to describe the pitiable plight of an insane woman who is forced to travel, sometimes for a day or so, with only a male attendant. Were the woman a criminal she would be treated with more respect and decency.

The Arkansas law is superior in this respect also to that of California. It declares that no woman shall be permitted to be taken to any asylum unless accompanied by a woman of her own class. Not only must a woman go with her, but this woman must be of her own station in life.

People talk of the abuse the insane receive in asylums. Let them rather strive to correct the abuse and cruelty practised before the asylum is reached. Says Dr. Stephen Smith, in the article already quoted, "one of the greatest sources of cruelty to the insane is their removal to an asylum by rude and coarse town and city officials."

For the comfort of the insane, for the convenience of the examiners, every large city and populous county seat should have a house of detention for the insane before they are finally committed.

The patient is often arrested in an unkempt and uncleanly condition, and should not thus be taken in public conveyances to the asylum. Much of the horror towards the insane is inspired by this uncared for and wild appearance. Were they first taken to a special receiving hospital, and then cared for by trained attendants, and washed and properly dressed, their transportation would attract much less attention, for it could be accomplished in many instances in an unobtrusive manner. The delay in such a place of detention would also give the examining physicians an opportunity of observing the patients, and of correcting a mistaken diagnosis. It would prevent many unnecessary commitments.

The present custom of placing these patients in the general receiving hospital in San Francisco is not to be commended. They are a disturbing element, and being there on sufferance, as it were, are neither properly nursed nor carefully watched.

Having finally arrived at the asylum, the sick man is again confronted with the idea of criminality, for he is placed upon a ward with insane convicts. The California law reads: "Insane convicts must be received into insane asylums." Such a section would never have been incorporated into the laws were it not for the ever-prevailing idea that the insane man is a criminal, and that there can, therefore, be no injustice in placing him in the same apartment with other criminals.

That every State should provide special quarters for its dangerous lunatics and insane convicts is fully appreciated by every asylum superintendent, and has been urged time and time again. Think for a moment of sending a sick relative to consort with insane convicts.

In closing, let me hope that the "Association formed for the protection of persons charged with insanity" will drop their present attitude of hostility to the medical profession, and that they will free their minds of the idea that unjust commitments are made. Let them appreciate that any injustice lies rather in the manner of commitment. If they will strive for a revision of our laws, in order that the insane may be better protected, I can assure them that the medical profession will wish them "God speed!"

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By Wallace A. Briggs, M.D., Sacramento, Cal., and
Henry Gibbons, Jr., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Tracheotomy.—In laryngeal diphtheria tracheotomy is indicated whenever there is danger of asphyxia from the presence of false membrane. Contraindications are relative, but never absolute. Ordinarily we should not operate upon children under six months in toxic diphtheria with badly swollen glands, or upon cases in which broncho-pneumonia has already developed. Some authors lay down the general rule that it is well to postpone the operation as long as the patient's general condition remains good; but this rule does not apply to those cases in which surgical intervention may prevent invasion of the trachea and bronchial tubes. Usually, when respiration continues difficult for several hours, and becomes increasingly more so, tracheotomy should be performed at once. Violent attacks of suffocation always necessitate an operation, and surgical intervention has sometimes restored a patient even after apparent death. Tracheotomy decided upon, the following special points should be observed: The instruments required are a straight, sharp bistoury, a probe-pointed bistoury, a tracheotomy tube, a dilator, false membrane forceps, and an ordinary hemostatic forceps. A few chicken feathers are sometimes needed. The size of the canula varies with the age of the patient, but a tube as large as possible should always be used. No. 00, from 6 months to 1 year; No. 0, from 1 to 2 years; No. 1, from 2 to 3 years; No. 2, from 3 to 6 years; No. 3, above 6 years. It is well to have at hand two tubes of different sizes, each furnished with tapes to tie behind the neck. The tube should be passed first through a doubled piece of court plaster, and then through several thicknesses of iodoform gauze. Place the child, wrapped in a sheet, upon a table covered with a mattress, the neck resting upon a stick of wood enveloped in cloth. Rapidly aseptize the region of the neck. One assistant should keep the child's head motionless and moderately extended, while another prevents the body from moving. If the patient is over 10 years of age, a little chloroform may be given. The operator, at the right of the patient, should grasp the larynx firmly, but not too tightly, with the thumb and middle finger of the left hand, then with the left index finger seek the cricoid. If, as sometimes happens, it is difficult to feel the cricoid, place the finger upon the lower edge of the thyroid. With the straight bistoury, held like a pen at the junction of the blade and handle, puncture the skin under the nail of the index finger—that is, just below the cricoid. Still holding the larynx, insert the left index finger in the wound, and find the rings of the trachea. Make an incision of from 1 to 2 centimeters in length, exactly in the tracheal middle line, not withdrawing the bistoury until air can be heard entering the windpipe. Quickly seize the canula by its outer extremity with the middle and index fingers, holding the thumb over its external orifice, and place it in the wound, with one end pointing toward the spinal column and the other toward the operator. The tube is at first in transverse relation with the child's neck. It easily enters the tracheal wound, and it may then be lightly turned and carried into position. The operator may now release the larynx, tie the tapes behind the neck, and raise the patient. If the tracheal incision is too small, enlarge it with the probe-pointed bistoury; and if further difficulty ensues, insert the dilator, and introduce the tube between its branches. Apparent death is not rare after tracheotomy, when the operation has continued too long, or has been undertaken too late; but the following remedies are often efficacious: Irritation of the trachea and nostrils with a feather; artificial respiration, according to Sylvester's method; and traction of the tongue, according to the method of Laborde; ether, caffein, oxygen. Hemorrhage always ceases on the introduction of the tube, the more quickly when the instrument is large. A few minutes after the operation remove the inner tube, and clean it in a weak solution of carbolic acid. If this precaution is omitted blood coagulates between the internal and external tubes, rendering it difficult to withdraw the former. This internal tube must be frequently cleaned with a sponge. In a fold of the tarletan cravat protecting the orifice of the tube place a small cotton tampon, wet in the following solution:

Iodoform	gm. 10
Eucalyptol	gm. 1
Creosote	gm. 2
Rum,	
Glycerine	āā gm. 30

Change the entire canula every 24 hours, and regularly dress the wound, touching it with steresol if false membrane forms about it. Continue the general treatment of diphtheria.—*Union Médicale*, January 20, 1894.

SURGERY.

By T. W. Huntington, B.A., M.D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and
G. F. Shiels, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

Tuberculous Ulceration of the Anus.—Hartmann (*Rev. de Chir.*) says that tuberculous ulceration of the anus is much less common than fistula and tuberculous abscess. He has seen 10 cases under his own care, and to these he has added 17 published cases, and 2 others communicated to him. Among these 29 cases there were 22 men, 6 women, and 1 child. From this the affection appears to be much more common in the male sex. In 12 cases diarrhea was a prominent symptom. According to Hartmann the disease commences insidiously, and is first recognized owing to the presence of slight pain during defecation. In the majority of cases the ulceration extends upwards as far as the level of the inferior extremity of the rectum; in 2 cases only out of the 29 cited was it entirely cutaneous. In nearly half of the cases enlargement of the inguinal lymphatic glands was observed. The growth of the ulcerations is very slow. After having attained a certain size they remain stationary if not treated. Hartmann recommends ablation of the ulcer with the thermo-cautery; or with the galvano-cautery, if the condition of the patient will admit of it. In some cases much good has followed the use of iodoform ointment after the greater part of the ulcer has been removed. If the general condition of the patient does not admit of these procedures, it is recommended that general treatment for tuberculosis should be carried out. Lastly, pain may be relieved by the use of opium suppositories, the application of chloral 1 per cent., or of a mixture of subnitrate of bismuth and iodoform. In one case success was obtained by applying a ⅛ per cent. solution of nitrate of silver regularly for 16 months.—*British Medical Journal*, February 10, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

Suppuration of the Middle Ear, Due to a Coffee Bean in the Nose.—Dr. M. D. Lederman reports the case of a child that had a discharge from the ear for two months. The mother noticed that the child had constantly rubbed and picked the nose for three months previously. Ultimately a nasal discharge appeared, which caused eczema of the upper lip. The family physician treated this nasal affection as a purulent catarrh. About a month after the nasal symptoms developed, severe pain was complained of in the left ear, which deprived the child of sleep for several nights. Suppuration continued for two months, when the author saw the patient. A profuse, offensive discharge filled the meatus, there being a perforation of the membrane in the posterior inferior quadrant. A muco-purulent secretion filled the left nasal chamber. Being unilateral, and recalling the history, the thought of a foreign body arose. On examination, obstruction could be felt in the middle meatus. The tip of a Pomeroy's ear syringe, filled with warm boracic acid solution, was introduced into the right nostril, and, on exerting some little pressure, a coffee bean was driven out of the left nostril with the fluid. An antiseptic wash was used, and in a week the nasal cavity and the ear discharge were entirely well.—*Medical Record*, April 14, 1894.

Amblyopia from Di-Nitrobenzol.—Simeon Snell reports several cases of amblyopia in people whose work exposed them to the dust of di-nitrobenzol. Benzol, a coal tar product, treated with nitric and sulphuric acids at high temperature produces di-nitrobenzol. This substance is used in the manufacture of explosives. The men employed in grinding and mixing are the most exposed to the injurious dust and fumes. The women and girls who fill the cartridges are also much exposed. It acts as a poison whether ingested, absorbed by the skin, or inhaled into the lungs. The constitutional effects of the poison are very marked. The symptom which calls the patent's attention to the eyes is the rapid loss of sight. The ophthalmoscope generally reveals a pale disc, sometime enlarged veins, contracted arteries, and slightly obscure borders to the disc. In most cases there was a central scotoma for red.—*British Medical Journal*, March 3, 1894.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. Simmons, Jr., M.D., Sacramento, Cal.

Gallanol in Eczema and Psoriasis.—In a brief article, P. Cazeneuve and Et. Rollet (*Lyon Médical*) call attention to the therapeutic value of gallanol in skin disorders, particularly in eczema and psoriasis. In certain forms of subacute and chronic eczema gallanol proved to be a first-class therapeutic agent. Cases cured by it show no tendency to relapse, but the use of the drug must be conjoined with a suitable internal treatment and regulation of the diet.

Under the influence of the medicament, itching and oozing disappear soon, and desiccation is rapidly established. For these cases gallanol may be employed in the form of powder, or in that of ointment with traumaticine, in the strength of .5, 1, 2, and 3 grammes in 30 grammes. In psoriasis, especially in the mild form of the disease, the action of the new remedy is decided. The agent can be applied with advantage to the scalp, face, and neck, since its action is more rapid than that of alkaline substances. In these cases gallanol may also be employed in the form of ointment with lard or traumaticine, in the strength of 1, 2, and 3 grammes in 30 grammes. The parts must be thoroughly cleansed before the application of the medicament. The authors have also obtained good results from the application with a brush of this solution: Alcohol at 93° F., 50 grammes; gallanol, 10 grammes; liquid ammonia, 1 gramme. In these proportions the ammonia exercises no caustic action. In old, rebellious cases of psoriasis, gallanol seems to be less active than chrysophanic acid, pyrogallic acid, and especially the iodo-chloride of mercury; but it has the advantage over these remedies in not being poisonous. Patients can handle the new medicament almost with impunity.—*Therapeutic Gazette*, February, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By Wm. Watt Kerr, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Ill Effects Following the Use of Phenazon (Antipyrin), Acetanilid and Phenacetin.—After a very carefully-conducted inquiry by the Therapeutic Committee of the British Medical Association (*British Medical Journal*), they report that their inquiries demonstrate that, in the large majority of cases, the ill effects have been the direct result of injudicious and excessive dosage. In reference to phenazon, they conclude that the ill effects are not of the frequency or importance ascribed to them by a wide-spread impression. Among the precautions to be adopted, the most useful one is to begin with small doses, not exceeding ten grains, and to be careful not to repeat them too frequently. The reports in reference to acetanilid, as compared with phenazon, point to a radical difference, not so much in the physiological action, for that in both cases is exerted chiefly on the circulation and nervous system, as in the power of the two drugs. Acetanilid is a much more powerful drug than phenazon. Speaking generally, it may be said that two grains of acetanilid are equivalent, as regards general therapeutic effect, to about ten grains of phenazon. The reports place the ill effects of acetanilid as of a much more severe character and of more frequent occurrence than those of phenazon, while there is no such direct relation of the ill effects to the dosage to be made out, as was the case with phenazon, indicating that acetanilid is more inconstant in its action, and correspondingly more dangerous than phenazon. They consider that to give acetanilid in doses of five or six grains, and still more to repeat these doses after a short interval, is a highly injudicious procedure. Phenacetin appears to be in exceedingly good repute with those who have had an extensive experience of it. Ill effects have been strikingly infrequent, and there is much unanimity as to the great value of this drug, especially as an analgesic. The initial dose that may be given with safety appears to be from five to eight or ten grains.—*International Medical Magazine*, April, 1894.

MEDICINE AND PATHOLOGY.

By Albert Abrams, M.D., Professor of Pathology, Cooper Medical College, San Francisco

The Treatment of Neuralgia.—Dr. C. L. Dana, in the discussion of this subject, confines himself to special forms of neuralgia. In the treatment of supra-orbital neuralgia, he had found a combination of quinine and the iodide of potassium of very great value. The mixture he prescribed consisted of 10 grains of the iodide of potassium and 10 grains of quinine, dissolved in a tablespoonful of water by means of a little citric acid. In trigeminal neuralgia, aconitin has a specific effect on that nerve. After eliminating any malarial element by the administration of quinine, Duquesnel's aconitin may be given in doses of $\frac{1}{200}$ grain, three to five times a day. The fluid extract of gelsemium sometimes has a specific effect. It is an ingredient of many popular neuralgia cures. Four or five drops of the fluid extract of gelsemium should be given, and the dose increased until the eyelids begin to droop. In brachial neuralgia, he found rest the most important element in the treatment. The patient should be put to bed and the arm put in a splint. Antifebrin, in 5-grain doses, with sodium salicylate, if given every four hours, will almost always break up these attacks. Much relief always follows local applications, and one of the most efficient, is spirits of chloroform 1 part, with 20 parts of a 20 per cent. solution of menthol, painted over the arm, and the arm then covered with absorbent cotton and bandaged. The effect of this application is very grateful to the patient. Leeches and blisters are often of service. In intercostal neuralgia, blisters applied over the painful point are very valuable. Respiratory movement should be inhibited over the implicated parts by the application of adhesive straps around the chest. Large doses of muriate of ammonia—half a drachm dissolved in considerable water—often have a specific effect, and phenacetin, also, often exerts a specially good action. These neuralgias are in many cases reflex and are due to pelvic, gastric, or pleuritic troubles. In sciatica of neuritic origin, rest is the most important factor. In the earlier stages, patients should be put to bed and a splint applied from shoulder to ankle, and over the course of the nerve, ice bags or hot applications should be applied. Repeated blistering is of great service. Freezing the tissues along the course of the nerve with chloride of methyl may be of value. In pelvic neuralgias, codein, belladonna, and muriate of ammonia are useful. A codein tablet dissolved in hot water may be given hypodermically and will produce nearly the same effect as morphin.—*Post-Graduate.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane,
Stockton, Cal.

Traumatic Psycho-neuroses in Children.—DR. VIBERT reports two cases of this kind in children 3½ and 5 years old. In the first case the child, in whose family there was no history of neuropathy, had received a light contusion on the forehead in a railroad accident, the wound healing in a very short time. The child became very much frightened at the time of the accident, screamed incessantly, and had to stay in bed for some days following the accident on account of headache, vomiting, sleeplessness, and great weakness. These symptoms gradually disappeared and the vomiting ceased, but the character and disposition of the child underwent a complete change. She became changeable, mostly melancholy; in the midst of playing she would stop and gaze fixedly without having convulsions or loss of consciousness, would frown, remain silent, or scream under the influence of visional hallucinations of fear, often urinate in bed when before she was cleanly in habits. The appetite became capricious, the pulse intermittent; there was no sugar in the urine. As far as could be ascertained the sensibility and field of vision were normal. The second case, which in many respects resembled the first, was that of a boy who had suffered a number of contusions by the falling of a scaffolding. The patient first became sick with symptoms of meningitis: loss of consciousness, delirium, continuous vomiting. After he had recovered from these symptoms he showed a great change mentally; he was almost always sad, very timid, and easily frightened; would wake up three or four times during the night suffering with night-mare, and now and then he was subject to exciting visual hallucinations. The author gave in both cases a not very favorable prognosis.—*Annales d'Hygiene Publ.—Allg. Zeitschr. f. Psychiatrie.*

The Use of Hypnotism in Cases of Insanity.—DR. G. M. ROBERTSON reports a number of favorable results which he has obtained in the application of hypnosis among the insane who, as a rule, are hypnotized with difficulty. He makes use of the remedy: (1) In sleeplessness, where the ordinary narcotics have been ineffectual, or are contraindicated. In a case of periodical mania he produced sleep lasting 4 to 6 hours, although average doses of chloral and bromide had been given without effect. (2) As a sedative in conditions of excitement, especially in epileptic and hysterical patients, also in certain periodical cases, provided the hypnotism be made before the excitement has fully developed, and the patients be made to sleep for some hours. (3) In mild attacks of insanity of short duration. He also applied it with benefit in a case of hypochondriacal melancholia with temporary confusion, and in one of stupor after frequent successive epileptic attacks. Hypnotic suggestion he has made use of to overcome the resistance of patients against taking medicine or food. He thus succeeded in getting patients to take sulfonal, and in getting a patient to take food who had had to be fed with the stomach-tube for over a week. The success of this treatment must, as a rule, be said to be uncertain. It is especially difficult to hypnotize melancholiacs, but very easy to hypnotize cases of simple mania.—*British Medical Journal—Allg. Zeitschr. f. Psychiatrie.*

FORMULÆ.

By GEO. B. SOMERS, M. D., San Francisco, Cal.

Freckles.—MORISON employs:

Corrosive sublimate	gr. vii
Distilled water	℥ vi
Spirits of camphor	℥ ss
Rose water	ʒ v

Three or four thicknesses of linen, cut to cover the seat of freckles, are moistened with the solution and placed upon the face at night until they dry, when they are taken off. After a few nights' application, the face becomes red and the epidermis begins to peel off in fine scales.—*Medical News.*

Borax in Epilepsy.—ALEXANDER gives:

Sodii bibor.	gr. 200
Sodii brom.	gr. 50
Syr. simpl.	℥ i
Aq.	*ad* ℥ x

S.—One ounce in water after meals. *New York Medical Journal.*

Remedy for Burns:

Carbolic acid	ʒ i
Sodium bicarb.	℥ i
Linseed oil	℥ viii–M

Apply on cotton batting, and exclude the air.—*Rocky Mountain Druggist.*

Flatulent Dyspepsia:

Bismuth subcarbonate	ʒ iii
Morphin sulphate	gr. i to ii
Aromatic powder	ʒ i

Make into 12 powders.

S.—One before meals.—*Pharmaceutical Era.*

Tonic Mixture.—PARSONS prescribes:

Fl. ext. erythrox. cocæ	℥ i
Tinct. gent. comp.	℥ ss
Elix. simplicis	*ad* ℥ iv

S.—Teaspoonful 3 times a day.—*Times and Register.*

Typhoid Fever. — The following emulsion is both palatable and efficacious:

Ol. terebinth.	
Albumin ovi	ãã ʒ ii
Glycerin.	
Syrup	ãã ℥ i
Spts. gaultheriæ	*ad* ℥ iii

S.—Teaspoonful every three or four hours.—*New Remedies.*

Oxalic Acid as an Expectorant.—POULET has employed this drug in asthma and capillary bronchitis, with good results.

Oxalic acid	gr. xxx
Infusion of tea	℥ vi
Syr. bitter orange peel	℥ iiss

S.—Teaspoonful every hour.—*Lancet-Clinic.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for March, 1894.—The deaths registered in 90 town districts of the State, during the month of March, in a population of 803,287, correspond to an annual rate of 16.56 a thousand, the total mortality having been 1,119. 151 deaths were due to zymotic diseases, giving an annual rate of 2.16 a thousand. Of these, 8 were due to diphtheria, 1 to cholera infantum, 13 to typhoid fever, 2 to diarrhea and dysentery, 10 to cerebro-spinal fever, 7 to whooping cough, 7 to croup, 2 to intermittent and remittent fevers, 1 to scarlet fever, 0 to measles, and 0 to small-pox. 367 deaths resulted from diseases of the respiratory organs, giving an annual rate of 5.47 a thousand. Of these, 202 were due to consumption, 115 to pneumonia, 39 to bronchitis, and 11 to pulmonary congestion; the rate being, for consumption and pneumonia, 3.12 and 1.70, respectively. 84 deaths resulted from diseases of the heart, 5 from alcoholism, 2 from erysipelas, 45 from cancer, and 509 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 578,500, was 17.88. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Stockton.

METEOROLOGY.

Summary for March.—*Temperature.*—The normal temperature of the State for March is 53°, the average for March, 1894, was 51°; a departure from the normal of —2°. The highest monthly mean was 72°, at Volcano Springs, in the desert regions of the State; the lowest, 29°, at Summit, in the high mountain regions. The maximum was 105°, at Volcano Springs, on the 28th; the minimum, 7° below zero, at Truckee, in the mountain regions, on the 3d. The absolute range in the State was 112°. The greatest monthly range was 67°, at Winchester, Riverside county; the least, 26°, at Point Lobos, near the entrance to Golden Gate.

Rainfall.—The normal precipitation for the State for March is 3.43 inches; the average for March, 1894, was 1.43 inches; a departure from the normal of —2.00 inches. The greatest monthly precipitation was 15.41 inches, at the Crescent City light house; the least, nothing, at Indio, in the desert regions of Riverside county.

Wind.—The prevailing direction of wind was westerly and northwest.

Unusual Features.—There are no unusual meteorological phenomena to record.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for March, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No. of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn ....Cal.	52.0	84.0	29.0	------	------	------	----	1.95	------	----	----	----	S.E.	Southern Pacific Company.
Berkeley......... "	47 0	69.0	34.0	57.0	43.0	14.0	6	0.91	82 0	12	9	10	N.	Obs. University of California.
Colfax........... "	47.0	70.0	24.0	------	------	------	----	3.63	------	----	----	----	W.	Southern Pacific Company.
Eureka.......... "	46.0	62.0	32.0	52.0	41.0	11.0	18	7 46	91.0	6	8	17	S.	Weather Bureau Dept. Agr.
Fresno.......... "	53.0	81.0	32.0	65.0	41.0	24.0	7	0.29	62.0	12	14	5	N.W.	" " "
Indio............. "	66.0	95.0	34.0	81.0	52.0	29.0	0	0.00	18.0	28	2	1	W.N.W.	Rev. Wm. Brennan.
Keeler. .... "	51.0	78.0	24.0	63.0	39.0	24.0	1	0.01	------	17	8	6	E.	Weather Bureau Dept. Agr.
Los Angeles.... "	54.0	82.0	35.0	65.0	43.0	22.0	3	0.37	70.0	12	11	8	W.	" " "
Monterey .... "	52.0	68 0	32.0	------	------	------	----	0 82	------	----	----	----	S.	Southern Pacific Company.
Napa........... "	53 0	76.0	33 0	63.0	43.0	20 0	6	1.15	56 0	12	13	6	S.W.	Station Napa Insane Asylum.
Oakland......... "	50.0	72.0	34.0	60.0	44 0	16 0	9	0.79	84.0	16	6	9	W.	Chabot Observatory.
Paso Robles.... "	51.0	85 0	28.0	------	------	------	----	0.22	------	----	----	----	N.	Agricult. Experiment. Stat'n.
Red Bluff....... "	52.0	76.0	30.0	60.0	43.0	17 0	13	2.40	68 0	10	12	9	N.W.	Weather Bureau Dept. Agr.
Sacramento. ... "	53.0	78.0	34 0	62 0	44.0	18.0	7	0.74	69.0	12	10	9	S.W.	" " "
San Bernardino "	54.0	85.0	28.0	68.0	40.0	28 0	3	1.15	65.0	15	11	5	W.	A. K. Johnson, M. D
San Diego....... "	53.0	72 0	36.0	60 0	44.0	15.0	5	1 05	77.0	15	8	8	W.	Weather Bureau Dept. Agr.
San Francisco.. "	51.0	66.0	37.0	56.0	45.0	11.0	6	0.60	75.0	12	11	8	N.W.	" " "
Santa Barbara.. "	53 0	74.0	34 0	62 0	45.0	17.0	2	0.29	70 0	17	6	8	W.N.W.	Hugh D. Vail.
Santa Cruz...... "	52 0	78 0	31.0	64.0	41.0	23.0	6	1.64	------	17	8	6	S.W.	W. R. Springer.
Yuma..........A. T.	63.0	95.0	33 0	78.0	48 0.	30.0	2	0.74	40.0	19	9	3	W.	Weather Bureau Dept. Agr.

T. means a trace of rain.

Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: MAY, 1894

THE MEETING OF THE STATE SOCIETY.

The twenty-fourth annual meeting of the State Society, while fairly successful, was less so than those of recent years. The cause of this can readily be found in the prevailing hard times, from which not even California has been exempt, and in the fact that the American Medical Association will meet in San Francisco in June. Were times more prosperous, many who will attend the Association meeting would also have been present at the meeting of the State Society; but that stringency, which the physician is the first to feel, influenced many to remain at home. Thus, the extreme southern section was represented by two members, and the northern district of the State by the same quota. Perhaps the most discouraging feature was the uniformly small attendance from San José and its immediate vicinity. On no occasion was this attendance large, and there were times when not a representative of the Garden City was present. Another factor in the limited attendance was the proximity to San Francisco and the facilities for transportation between the cities. Visitors from the metropolis arrived on the morning train to return in the afternoon, and frequently this was the only visit during the meeting. Finally, the local committee decided to give their entertainment on the second evening. It had been originally intended to hold the reception on the first evening, but wiser councils prevailed. The selection of even the second evening, when only one entertainment was given, was unfortunate, and it evidently conveyed the impression that the third day was of lesser importance, a theory which the greatly decreased attendance would seem to bear out.

The foregoing will, we believe, fully explain why the past meeting was not so successful as it, no doubt, would have been under other circumstances. In no sense can any of this failure be attributed to the presiding officer or to the local Committee of Arrangements. DR. KENYON has always been regarded as a worker, and both in preparing for the meeting and in unremitting attention during the sessions, he more than fulfilled his part. The Committee of Arrangements also seemed to have done all that was possible, and it was of course out of its power to compel an attendance of the local profession. The selection of the hall for the meetings was unfortunate. The acoustic properties were poor, the light could hardly be considered good, and the temperature of the building was frequently so low as to compel even gentlemen from San Francisco to wear their overcoats. These are minor discomforts, but they helped to render the meeting less attractive.

The papers presented were uniformly good. That by DR. W. S. WHITWELL, on "The Commitment of the Insane," was very timely, and deserves the earnest attention of the profession, and even more so of the public which is most concerned. In their treatment of the insane the people are badly in need of education, and it seems as though less progress were made here than in almost any other branch of popular education. DR. H. M. SHERMAN'S paper on "The Sources of Contagion of those Forms of Tuberculosis Usually Seen in Children," is a much needed step in the direction of establishing a more precise knowledge of the primary stages of these affections, in which the author has had an extended experience. DR. W. J. G. DAWSON must also receive his share of credit for pointing out the acknowledged, yet less widely known, advantages of Napa and Lake counties as places of permanent residence for delicate persons and for convalescents. A noticeable feature of the program was the showing made by the eye, ear, nose, and throat specialists. The best men were represented by good papers, and the material was more than sufficient to occupy an entire session. On the whole, the number of papers presented was far more than could have been read and profitably discussed. Several, however, were not presented, and several were read by title, thus making it possible to get through the work of the meeting. As usual, a number of papers were not on hand when called for, and had subsequently to be taken up out of order. There is nothing that so tends to demoralize the program as this irregularity. It is disappointing to the author and to the audience, and it is fatal to an instructive discussion. Those who expect to take part in a debate are present at the appointed time only to find that the paper will not be read, and they are unlikely to return at a later hour. The papers should be completed and in the hands of the Committee of Arrangements before the meeting, so that in the absence of the author, each can be read in turn. This cannot always be accomplished, but by steady effort better results are possible. In this connection, a feature of the program before us, and one that, with a single exception, has been the stereotyped custom for years, is the assigning an hour at which a certain paper shall be read. As a result of this the presiding officer is compelled to interrupt an interesting discussion to permit the reading of a paper on which no one will have a word to say. A far better method is to apportion the work for each session without specific hours, and leave the further management to the presiding officer. He can thus, according to his judgment, encourage or curtail discussion, and prevent waste of valuable material.

The emphatic and unmistakable declaration of the PRESIDENT in relation to the Code of Ethics of the American Medical Association should long be remembered in the Society. Its unanimous endorsement shows that, in California at least, there is no misconception on this question of revision, and the delegates of the State Society will record its vote as against any change in the direction now proposed. The State Society has been ever regardful of the parent Association, and during the past twenty-four years has always been loyal to the absentee. The Pacific Coast—indeed, the whole Western States—have been shamefully neglected by the Association, but we firmly believe that with the coming meeting there will be inaugurated a new era. It behooves the profession of the Pacific slope to demonstrate by attendance and participation, and by a substantial increase in membership, the earnest satisfaction that it takes in the visit of the National Association. The State Society has set a good example by appropriating its entire available funds that California's hospitality may be as well remembered by the visitors as it seems to have been by those who were with us many years ago.

The Society has honored itself in the election of DR. G. L. SIMMONS, of Sacramento, as its President. DR. SIMMONS has been a pioneer in the medical history of our State, and it is most fitting that the American Medical Association should be welcomed here by one of its oldest members, who has at the same time been identified with the earliest medical history of our State. We believe we are fully justified in saying that to no one man does medical organization in California owe more than to DR. SIMMONS, nor has any been more constant and unremitting in the cause of the profession, during all the years of his long and active life amongst us. His capacity for the office to which he has been elected is too well known to need recommendation at our hands, and we predict a most successful meeting in San Francisco in '95.

San José is a beautiful city—a city of homes, and gardens, and flowers—which rapid improvement on modern lines is rendering more attractive. It has an excellent hotel—the Vendome—of a type far too uncommon in Northern and Central California. A very pretty reception was tendered to the visitors, at the Vendome, on the evening of the second day of the session. The large ball-room was filled with visitors and many of San José's best citizens, and in due course supper was served in the dining-room of the hotel, whose capacity was ample for the many hundreds present. Several toasts were proposed and speeches made, and the occasion was certainly a very enjoyable one. San José has ample facilities for making a good meeting, and it will be only fair to that city to give her, under more favorable circumstances, an opportunity in the near future to demonstrate what she can really do in this direction.

PROPOSED REVISION OF THE CONSTITUTION AND BY-LAWS OF THE AMERICAN MEDICAL ASSOCIATION.

At the meeting of the American Medical Association, to be held in San Francisco, in June, the draft of the constitution and by-laws, as revised and submitted by the committee of the Association, at Milwaukee, will come up for final action. During the past nine months we have kept the report of this committee, in the form of the revised constitution, constantly before our readers. It has been published as a supplement in every issue of THE MEDICAL TIMES, and has, we believe, been seen by every physician in the Pacific coast States and Territories. Its appearance will cease with the present issue, as at the time when arrangements for its publication were made, the date of the meeting had been fixed for May. Those of our readers who are not already thoroughly familiar with the proposed constitution will therefore do well to carefully study the changes which directly concern the profession on the Pacific slope, and, indeed, all members of the profession that do not reside within a very limited radius of the larger eastern cities.

The principal changes are, the abolition of the Nominating Committee, whose duty it is proposed to turn over to the General Business Committee, and, in line with this change, the abolition of delegates from the various affiliated Societies. As now constituted, the Nominating Committee is composed of one representative from each State and Territory, and from the Medical Departments of the Army, Navy, and Marine Hospital Service. Each representative is elected by the delegates from his State who are present at the meeting. The duties of the Nominating Committee are to select the place of meeting, to nominate officers for the ensuing year, and to select members to deliver the general addresses in Medicine, Surgery, etc. Under this provision the Nominating Committee is as nearly representative of the profession of the whole United States as it is possible to make it. The General Business Committee, which will consist of chairmen of the several sections, will, as can plainly be seen, fall far short of the representative nominating convention. The chairmen of sections are elected each year by those members registered in the various sections. During all the years of its history, the Association, with rare exceptions, has held its meetings within a very limited territory. The attendance at the meetings has, therefore, been confined to members drawn from that territory. The representation of the west and south on this Business Committee will, therefore, be practically *nil*, and this condition will probably continue for many years to come. Under the present arrangement the central and eastern States will generally have a majority, as States in the far west and south may not be represented by a single delegate. Taking the meetings year by year, it will, however, be found that these distant States will far more frequently have a voice in the nominations than will be possible under the proposed change.

The second change that is being advocated—the abolition of the delegate system—and conferring the voting power on every member of the Association present, has an even graver significance. During the meeting, and at the general sessions, the right to vote on all matters of business and in things concerning the general conduct of the Association, rests solely with the delegates. These delegates are appointed by the various State and local societies in affiliation with the Association, and in the proportion of one delegate to every ten or fraction of ten of the membership of these societies. It will, therefore, be seen that while the locality contiguous to the place of meeting will inevitably be represented by a larger number of delegates than more distant sections, yet at the same time through this representative system it will be prevented from having absolute control of the proceedings. Under the existing system every vote counts as 1 to 10; the votes, therefore, of delegates from distant sections, while bearing the same relation to the numerical strength of the profession in each locality, will represent a far larger voting power than would be possible under the proposed change. This, if carried out, would destroy the present representative character of the Association by practically disfranchising the West and South. There does not seem to be any sound reason for this radical innovation. It is said that the present arrangement is unfair to the permanent members who, being deprived of the right to vote, have thus lost interest in the proceedings. Such a contention seems hardly reasonable. The scientific work of the Association is conducted in the sections, which are not concerned by the present system. Nor does the alleged disability prevent any member from taking every part in the proceedings except that of recording his vote.

The whole question is largely one of public policy. It resolves itself into the plain issue whether the present representative character of the Association shall be maintained, or whether the affairs shall be turned over for the time being to the profession of that State in which the meeting will be held. No more forcible example of this could be cited than the coming meeting. Under the proposed change California and the adjoining States would practically have control of affairs. As it is this State will have only her proportionate representation. This occasion has, so far, occurred but twice in 50 years, in the remaining 45 the western States had everything to lose and nothing to gain by such a change. It is manifestly to our interests that neither of these reforms be adopted. There are other changes, as the abolition of the general addresses, that would certainly withdraw a very interesting feature from the general sessions, and the proposition to make the "American Medical Association" include Canada and Mexico. This latter, in the absence of any very urgent desire on the part of our neighbors to participate, may best be regarded as premature. In conclusion, we commend to the careful attention of our readers a letter from Dr. N. S. Davis, that will be found on another page.

AMERICAN MEDICAL ASSOCIATION.

Membership in the American Medical Association.—"This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues and subscription for the *Journal.* Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly *Journal* of the Association will be forwarded regularly."

Application Blanks for Membership.—On advertising page xxvii we print a convenient form of application blank that is being circulated by the Association *Journal*, Any physician desirous of joining the Association can cut out this blank, and, having properly filled it, can mail same with his subscription to the Treasurer. As many physicians seem to be waiting for these blanks before joining the Association, it is pertinent to remark that the blank is not a necessity but merely a convenience. The essential is a certificate signed by the President and Secretary of a State or local Medical Society, and this, accompanied by $5, will be duly honored by the Treasurer. Meanwhile our readers will find each month the regular application form in our advertising columns, and we shall be at all times ready to afford any information in these matters.

Place of Meeting.—The Committee of Arrangements has secured Odd Fellows' Hall, corner Market and Seventh streets, as the place of meeting for the general sessions and the sections. This building furnishes one large hall with a seating capacity of 1,500, and twelve halls that can accommodate from 500 to 100 persons. There are also committee rooms in the building. This enables all the Association work to be carried on under the same roof, a very desirable feature that has not always been possible in other cities. It permits members to be present at different section meetings on the same day with the least possible loss of time, and by this concentration will tend to prevent stragglers. The acoustic properties of the main hall are good, and there is a large gallery for the accommodation of visitors.

Headquarters.—The headquarters of the Association will be at the Palace Hotel, corner Market and New Montgomery streets. It is, therefore, on the same street and just four blocks from the place of meeting. It should be mentioned that the whole of the Market-street system of cable cars traverses these four blocks—the Hayes, Castro, Valencia, and McAllister-street lines coming into Market street at Odd Fellows' Hall. This provides a car each way every few seconds, a service that is certainly not surpassed in any American city. The Registration Bureau, Association Post-office, etc., will be in Marble Hall, close to the hotel vestibule, and committees will meet in Parlor A on the first floor One of the many features of the Palace is its central covered court, which will make it pleasant for the ladies when going to or coming from the different entertainments.

Postoffice.—Station K is located in the Palace Hotel, on the office floor adjacent to the Registration room, where members can receive all mail matter by having it so addressed.

Itinerary of Excursions.—The Itinerary of Excursions, with cost of same, that was published in our issue of April, has led to so many inquiries for copies of that number that we have decided to republish it in the two issues remaining before the meeting of the Association. It will, accordingly, be found after the last page of this number, and will also appear as a supplement in the June number.

The Committee of Arrangements.—In our issue of March, the names of the the Committee of Arrangements were given. Through some error, the name of

DR. H. BERT ELLIS, of Los Angeles, was omitted. DR. ELLIS is the Assistant Secretary of the Association, and is, therefore, *ex officio* a member of the Committee. The name of MRS. ELLIS (DR. LULA T. ELLIS) was also omitted from the Ladies' Committee of Arrangements. For these errors we respectfully apologize.

Paso Robles and the Association.—In our Itinerary of Excursions, on page 219 of our issue of April, the well-known Hot Springs of Paso Robles were mentioned as worthy of a visit. We took the liberty of stating, on our own authority, that a special reduced rate would be offered by the Paso Robles Hotel Company to members of the American Medical Association desiring to visit the springs. We have received a communication from MR. E. F. BURNS, the manager, who states that the regular rates are from $2.50 to $4.00 per day, and that he will be very glad to make a reduction of 50 per cent. to any of the visitors. Times are hard, else, we have no doubt, even more liberal terms might have been offered. Yet, we feel justified in stating that if any member of the Association reaches Paso Robles "dead broke" that Mr. Burns will feed and lodge him on his personal note.

Highland Springs.—Highland Springs is situated in an arm of the great Clear Lake Valley, in Lake county, and has long been recognized as a pleasant and invigorating health resort, apart from the medicinal value of its waters. The management is desirous that members of the Association should pay them a visit. MR. J. CRAIG, the manager, states that if a party is formed he will procure the lowest possible railroad rates, and will extend the limits of his hospitality *free* to the visitors during their stay at the Springs. This courtesy has been extended through DR. H. D. LAWHEAD, of Woodland. The attractions of Lake county—often called the Switzerland of America—are many and varied, and will well repay even a brief visit.

The itinerary will be as follows:

Leave San Francisco (Tiburon Ferry)	7:30 a. m.
Arrive Pieta	12:00 m.
Leave Pieta (by stage, 12 miles)	1:00 p. m.
Arrive Highland Springs	2:30 p. m.
Returning, leave Highland	10:30 a. m.
Arrive Pieta	12:00 m.
Leave Pieta	1:00 p. m.
Arrive San Francisco	6:00 p. m.

SOCIETY PROCEEDINGS.

THE MEDICAL SOCIETY OF THE STATE OF CALIFORNIA.

Twenty-fourth Annual Meeting, held in San Jose,
April 17, 18, and 19, 1894.

FIRST DAY—TUESDAY, APRIL 17—MORNING SESSION.

The Twenty-fourth Annual Meeting was held in Germania Hall, the Society being called to order by THE PRESIDENT.

Address of Welcome.—ROBERT CALDWELL, of San Jose, the Chairman of the Committee of Arrangements, said: Mr. President, Ladies and Gentlemen of the Medical Society of the State of California: On this, the twenty-fourth annual meeting of the Society, the Santa Clara County Medical Society, and the medical profession of Santa Clara County, bid you welcome and extend to you one and all a most heartfelt and fraternal greeting. We are glad to see you, and hope that you will look back upon this meeting as one of the bright periods and one of the many pleasant memories of your professional life. When we look backward only twenty years, we may well be amazed at the progress of medical and surgical sciences. Only think for a moment of the advances of surgery, of medicine, and of the treatment of the diseases of women. Only two decades ago the knee joint was opened with fear and trembling; the abdominal cavity was a *noli me tangere*, and who dared perform operations which are now an every-day occurrence in the smallest hamlets of our State? And what a boon has advanced gynecology been to women. All this and more, too, do we owe to the hard-working, self-sacrificing medical man the world over. We meet here in this, the twenty-fourth annual meeting of our Society, to renew friendships, to exchange views, and to hear the papers on the various subjects which our program indicates. It is now many years since we had the pleasure of meeting you here in San José. Many who were with us then have gone to return no more, some few of us remain, and new men have appeared upon the scene; but we all, new and old, are glad to have you with us once more. The Committee of Arrangements has been flooded with papers, and it has taken a deal of work and thought to arrange the program. Much is due to our President, Dr. Kenyon, and to the Secretary of the Committee, Dr. Wagner, for their work and advice. We must confess that the time given for reading the papers, and for discussing them, is far too short; but it was impossible to help this unless the time of the meeting was greatly extended.

Annual Address.—The Annual Address [published at p. 241] was then read by the President, C. G. KENYON, of San Francisco.

AFTERNOON SESSION.

Committee on Publication.—The Chairman of the Committee, A. P. WOODWARD, of San Francisco, being absent, his report, which had already appeared in the transactions of 1893, was read by the Secretary, W. WATT KERR, of San Francisco. The report alluded to the continued infraction of Art. IV, Sec. 3, of the By-Laws, regarding the publication of papers elsewhere than in the Transactions, and suggested that the penalty for this offence be made more stringent or else that the section be repealed.

Committee on Diseases of the Mind and Nervous System.—The report of this committee (published at p. 266) was read by the Chairman, W. S. WHITWELL, of San Mateo, the subject being, "The Commitment and Discharge of the Insane."

DR. C. G. KUHLMAN, of San Francisco, said: I cannot personally agree with Dr. Whitwell as to the injustice of the laws relating to insanity in this State. I have been instrumental in the commitment of insane people, and have received the utmost courtesy from the commissioners of insanity and from the presiding judge. If there is any injustice done in these cases it is due to the incompetency of the attending physician and the inhumanity of the friends of the patient. Not long ago I had one of my patients committed to Stockton and got him before the commission without his knowing anything about it. I went to his house with a carriage, accompanied by a policeman dressed as a civilian, and I told the patient we were to take him before a friend of mine, who was a physician, and consult him in regard to his condition. In this manner we got him before the commission without any undue publicity. I cannot complain of any rudeness on the part of reporters, or any one else assembled in the room where the commitment took place. It is sometimes utterly impossible to commit insane people without their being aware of it. Where patients suffer from illusions or momentary spells of insanity, as it were, it will dawn upon them where they are and what is going on, and they of course will object, and we will have a display of resistance, a display of inhumanity, a display of injustice. This cannot possibly be avoided. I believe we should commit insane people early. In the east one of my patients, a lady, killed her brother, and I felt that it was my fault. I knew that the case was incurable, and I knew it was only a question of time when she would commit some violent act. I had held out against commitment on account of the friends until it was too late. Since then I have made up my mind that I will commit early in all cases where I recognize incurable insanity. I cannot agree with Dr. Whitwell in regard to any inhumanity or any injustice on the part of the commission, or on the part of the judge committing; at least such are not my experiences in committing insane. I am satisfied if the examining physician is capable and takes the proper precautions, and is skilled in these cases, there will be absolutely no injustice done to the insane—in this State at least. I certainly agree with the author that no one is unjustly detained in an insane asylum—in this country at least. There may be isolated cases in the old world where they are held for political or other reasons, but I am satisfied that there is no unjust detention of the insane in the United States.

DR. W. WATT KERR, of San Francisco: I do not think that the reader of the paper complained of any one being incarcerated in an insane asylum unjustly. The difficulty was to get those mild cases to which the speaker referred put under restraint. I do not think that any one can easily have an insane patient committed in San Francisco. The idea has got abroad that patients, unless they are actually violent, should be kept in a hospital, and the result is that over and over again those patients are sent to the County Hospital, and several of them have come under my charge. This spasmodic sentimental virtue that broke out about the end of last year caused quite a number of patients to be sent there, who should have gone to an asylum. These patients cannot be treated in a hospital. As Dr. Whitwell has said, they annoy the other patients, whose lives are endangered, not only from actual violence, but from disturbance. I am sure Dr. Whitwell, and all of us, are very well satisfied if we could commit early we should do so. Dr. Whitwell himself has reported the result of one or two cases which were not sent to the asylum, or which were delivered from the asylum. I could give you the result of two or three more. The trouble did not lie with the insanity commissioners; it arose when the matter was taken out of the hands of those commissioners, and when the judge was influenced not to commit such patients. There was one patient whose history appeared in the newspapers, but the subsequent events were not published. This patient, we were told, was refused commitment by the judge, although he had been detained for some time in the Home for Inebriates. He had there chewed up Dr. Potter's leg. The doctor's leg was bitten and kicked. Notwithstanding that, the judge said this patient should be an inmate of a hospital and not of an asylum. The patient was violent, and yet the judge would not commit him. He was sent out to my service at the County Hospital. When I first saw him he shouted, "I am John W. Mackay. Doctor, you are my friend." He called to my assistant and said, "Sign a check for $3,000,000 and give it to the doctor, and then see me out of here." He had an idea that every one there wanted to shoot him. The attempt made on Mackey's life was running through his brain all the time. In the course of a few days we got him sufficiently quiet to be relieved from restraint. Suddenly he pounced upon a helpless old patient about eighty years of age, threw him down, got some ropes and tied them all up in a knot. Afterwards the judge, on the representation made to him, rescinded his decision. It was rescinded very quietly; there was nothing about it in the newspaper, as in the former case. The patient was sent to an asylum. This patient was violent from the very start. I thoroughly agree with the author, that there is great difficulty in getting mild cases to an asylum. I do not believe that there are any patients confined in our asylums unjustly.

Committee on Medical and Surgical Diseases of Children.—The report of this committee was read by the Chairman, H. M. SHERMAN, of San Francisco, the subject being "The source of contagion of those forms of tuberculosis most commonly seen in children." The paper dealt with the necessity for the systematic prophylaxis of tuberculosis. The speaker said that out of 1,735 cases of children under 15 years, in the Children's Hospital, 292 had tuberculosis, or 16.8 per cent. of all. Of these, 251 had bone tuberculosis, 85.9 per cent. of all tuberculosis cases. He estimated on various authorities that the death rate of bone tuberculosis was 20 per cent., and of all tuberculosis in children 31.1 per cent. With these facts, the school census in San Francisco, and the deaths in San Francisco at this age due to tuberculosis, he estimated that about 1 child in every 286 of the child population of San Francisco had tuberculosis. He mentioned some efforts to instruct the people, more especially by trying to trace each case of tuberculosis in children to a probable source of infection, searching especially for direct infection by a tuberculous person, or by the use of tuberculous milk. The latter plan of inquiry was useless, because so few knew whence the milk they used came. Eight cases of tuberculosis in children were given where the infection was traced to a probable source. Of these, 4 were traced to personal contact with people ill of pulmonary tuberculosis; 2 to probable infection from infected rooms or houses; 1 to milk from a tuberculous cow, and 1 to the child's having been put into a hospital ward where tuberculous cases were treated. Statistics were quoted which showed that in Philadelphia over 700 lives a year are estimated to be saved by instructing the people in the contagiousness of the disease and in its prophylaxis. Attention was called to the especial necessity of this in California where there are many imported, as well as the domestic cases.

A Case of Intestinal Obstruction.—KATE I. HOWARD, of San Francisco, reported the following case: The patient, a child of 4 months, when first seen, April 8, 1893, presented the usual symptoms of intestinal obstruction. The previous history was good, except that occasional attacks of so-called "colic" had occurred at intervals from the time of birth, which were invariably relieved by a simple cathartic. These attacks had latterly become more frequent and persistent. In all other respects the patient appeared quite normal, a well-nourished, healthy baby. The onset of the present attack was sudden, being ushered in by violent retching and great distress. The usual cathartic was administered, but was at once rejected, and at the time of my visit the vomiting was persistent, but not fecal; constipation absolute; no tenesmus. The abdomen was not distended nor tender to the touch, but a movable tumor, the size of a small hen's egg, was discernible in the right inguinal region. The temperature was slightly above normal; the pulse small and very rapid; the countenance pinched and drawn. Neither cathartics nor enemas had the slightest effect. After a few hours the vomiting ceased, the abdomen became somewhat distended, and the little patient sank into a comatose condition. The parents refused all operative interference, and the child died in 24 hours from the commencement of the attack. The *post-mortem* examination revealed no signs of commencing peritonitis, all the abdominal organs being in a normal condition except the ascending colon, just above the cecum. Here a fibrous band was found completely occluding the intestine. It was very dense and firmly attached on either side to the pelvic bone. The bowel itself was greatly constricted at this point. Directly below this was the tumor, a fecal accumulation. The intestine was not gangrenous. The fibrous band was undoubtedly congenital. The speaker concluded by reviewing, at some length, the literature of the subject.

DR. W. F. CHENEY, of San Francisco: I feel particularly interested in Dr. Sherman's paper and in his investigations as to the frequency of the occurrence of these diseases in children. For the last few months I likewise have been trying to get at the frequency with which the disease occurs in children. The opportunities that have been afforded me have been those at the clinic at the Cooper Medical College. While I have no statistics to offer to corroborate those given by Dr. Sherman, I wish to add my testimony to the great frequency with which this disease does occur in children in one or another of its forms. I wish, also, to speak of the relation of tuberculosis in parents to tuberculosis appearing in children. I have made it a point in all cases that gave any suspicion of being tuberculosis, to enter at length into the family history, to learn, if possible, how the child acquired the disease. Almost always there is somewhere in the family a tuberculosis case, if not in the direct progenitors—the father or mother—then either in the ancestors of the father or of the mother. I recall a case of hip disease which I saw at the clinic two weeks ago. A little girl, five years of age, with a marked form of coxitis. The father and mother were both well, and, by further inquiry, I found that in the mother's family there had been nine deaths from tuberculosis; in fact, all of the other brothers and sisters in her family had died of consumption or of some form of tuberculosis, and she herself was the only one left. The question that arises in this and in similar cases is, How does the child acquire tuberculosis? There is direct proof in but very few cases, so far, that the bacilli of tuberculosis can be transmitted from the parent to the child. But there is, on the other hand, a vast array of evidence to show that the child of tuberculous parents, or of parents that have had tuberculosis in their family history, is more apt to contract the disease than one without such family history. How are we to explain this condition of affairs?

The only explanation seems to be that, although there is no transmission of the bacilli of tuberculosis, there is transmitted to the child a condition of anemia, and particularly a condition of diminished resistance to all sorts of contagion. To satisfy myself in regard to this point, I have carefully investigated every case of tuberculosis occurring in children, with regard to contagious diseases, and I find that the child that has tuberculosis in almost every instance will give a history of having had a number, if not all, of the other contagious diseases—measles, scarlet fever, diphtheria. From this I draw the conclusion that the child of tuberculous family history is peculiarly susceptible to all sorts of contagion, and offers a diminished resistance, not only to the bacillus of tuberculosis, but to all other forms of germ diseases. It seems to me that in this way, and in this way alone, is the child of tuberculous parents apt to contract tuberculosis. The other side of the picture should also be borne in mind, that the child of tuberculous ancestry is not condemned to tuberculosis. If parents can be taught that their children, even though they themselves are tuberculous, may escape by proper care, what a great amount of good can be done. If parents can be taught that by affording their children every opportunity for fresh air, sunshine and good food during their early lives, they can be put in such condition that their tissues will be more resistant and that they will be less apt to contract tuberculosis. Even if the child, as Dr. Sherman has told us, is thrown into contact with people who have tuberculosis, we know it is possible for the system to throw off germs of all sorts if it be in proper condition. If the child of tuberculous parents can be kept healthy and given good blood, and if it can be given fresh air and good food, there is no more reason why it should contract tuberculosis than the child of parents that have no tuberculous history. We must not condemn the child of tuberculous parents to tuberculosis. The probabilities are in favor of its contracting such disease, but it is possible to prevent it, and it lies within our power as physicians to do so.

DR. H. D. ROBERTSON, of Yreka: I must beg to differ with Dr. Cheney in regard to children that are naturally scrofulous and unhealthy being more susceptible to contract the contagious diseases than others. My experience has been that the children who most readily contract diphtheria and measles are the very healthiest children, whose secretory organs and glands are in a peculiarly active state. About eighteen years ago, I think it was, I called Dr. Caldwell, of this city, in consultation in an epidemic of diphtheria in the little town of Mayfield, and Dr. Caldwell at that time, in connection with Dr. Thorne, called my attention to the fact that most of the children recovering from that severe condition of diphtheria were children that were naturally a little scrofulous. The healthier the child, the more active they were; and the more full-blooded, the more the disease seemed to progress. It seems to me that children that are naturally scrofulous and unhealthy have greater immunity from many of the other active contagious diseases than the healthier class of children. I would like to ask Dr. Sherman, Does he consider scrofula an inherited disease, or does he regard the disease as sometimes originating anew?

DR. SHERMAN: I do not know what scrofula is. As I understand the word, it describes a clinical condition, and not a pathological state. A child having scrofula, who has large lymphatic glands under its neck, has those glands enlarged from one of two causes, tuberculosis or syphilis. Ninety-nine times out of one hundred it is tuberculosis, although scrofula describes a child that has tuberculous lymphatic glands.

DR. C. G. KUHLMAN, of San Francisco: Dr. Cheney has said, and I believe the general trend of the paper was to show, that there is no such thing as inherited tuberculosis, direct from the mother or father. This is erroneous and fallacious. The latest scientific investigations on that subject were published in March, 1893—one work, by Bang, on tuberculosis, and one by Gartner on inherited tuberculosis in human beings. These works are classical, and are accepted as authorities in the old world and in this country on inherited tuberculosis. From the investigations conducted by Bang, upon an extensive scale, he has shown that the bacillus of tuberculosis is directly transmitted from the mother to the fetus *in utero* and to the placenta. Gartner has shown that the bacillus of tuberculosis is directly transmitted *in utero* to the fetus and placenta; which is directly opposed to the theory that has been expressed here, that tuberculosis is not transmitted that way. According to their investigations, which were fully borne out by experiments, not only upon calves, but on guinea pigs and other animals, and on canaries, Gartner showed that the bacillus of tuberculosis found its way into the fetus in four ways: First, through the semen *in utero.* The bacillus found its way through the fallopian tubes into the ovaries. The experiments showed that the ovum might become infected, not only in the fallopian tubes, but in the womb itself. We all understand the peculiar anatomical arrangement of the fetus; the direct connection between the liver and the cord. We find, in cases of inherited tuberculosis, few, if any, bacilli in the lungs. We find them distributed through the liver, the direct route that it takes through the cord, as it enters the general system of the child. There we find them mostly implanted. The primary focus of implantation is in the fetus or in the placenta, and then we have a secondary implantation in the liver, in the spleen, and in various other parts of the organism; rarely, if ever, in the lungs. This has been thoroughly demonstrated within the last year, and goes to show that tuberculosis is directly inherited by the fetus *in utero.*

Dr. Sherman: I will confess that the two valuable and classical works mentioned by the last speaker have not been at my disposal, nor have I, in the reading that I have been able to do, come across them. I am aware that a number of years ago a calf was born tuberculous of a tuberculous cow. That, so far as I knew, was the only recorded case of tuberculosis being transmitted *in utero.* Keating also called my attention to a case of Dr. Jacobi, of New York, where a child died of tuberculosis a very few days after birth; but the tuberculosis was proven by *post-mortem* examination and not by a bacteriological test; so that it can hardly be accepted as an actual case of tuberculosis. That other organisms than the bacilli of tuberculosis have been transmitted from the mother to the child *in utero* is also well known, more especially in women ill of scrofula. That the bacilli of tuberculosis were so transmitted is possible to conceive, but clinically we do not have it transmitted in that way very often. We do not see tuberculous children necessarily born of tuberculous parents. It is the experience of all of us that we see puny, weak children born of tuberculous people, and that they afterwards can grow up hearty and healthy, because I know a great many of them myself. The danger is not so great as it would seem: and in all these cases that I have reported the family histories have been perfectly good; there has not been a particle of question of the mother infecting the child.

Committee on Medical Jurisprudence.—G. W. Davis, of San Francisco, the chairman of the committee, said: An eminent medical jurist had defined "Medical jurisprudence, or forensic medicine, to be that science which teaches the application of any branch of medical knowledge to the purpose of law." In a general sense, jurisprudence is both the philosophy and science of law—as science it teaches the facts and principles of all actual law. Of the many questions that could be presented and discussed in a report of this kind, there are none of more importance than that of medical expert testimony, because it is very largely, if not entirely, through the scientific expert knowledge possessed by intelligent medical men that all questions of medical police, public hygiene, and the commitment of the insane, are dealt with, and in which the general public is justly the beneficiary. Upon a correct knowledge, and consequent interpretation of the duties and privileges of a medical expert, depends very much the proper application of scientific truth in protecting the innocent and fastening guilt where it belongs. The services of medical jurists seems, during a very recent period, to have been required in many trials throughout our country. Much complaint has been made as to the character of medical witnesses; some of these witnesses were experts in the true sense, while others were totally unfit to be considered in any such capacity; and quite often is published alleged "expert" testimony in which there was a painful exhibition of ignorance of the simplest rudiments of an ordinary medical education. If the judge would have authority to accept or to reject a witness offered as an expert, and would exercise it, after a careful and rigid examination of the qualifications of the witness, very much would be gained to the cause of justice and right, and to the dignity and honor of the profession. The medical examination of the insane should demand our serious attention and careful consideration, Every physician has either known or read of cases where the severest wrongs have been, purposely or not, perpetrated by wicked, designing persons upon individuals charged with insanity. Every person charged with being insane to a degree requiring the interposition of the authorities, must be given an opportunity to be heard in court, which is to decide upon his right to his personal liberty in the future, and this deprivation of liberty should not be upheld unless absolutely secured by due process of law. Upon this very important part of this report, Dr. J. R. Medlock, of Santa Ana, a member of the committee, very clearly expresses his views as follows: "The manner in which persons charged with insanity are tried and committed to the asylums is exceedingly faulty, and ought, in justice to both the accused and the state, be changed. I have known a number of mistakes made by examiners that have resulted in great injustice, sometimes to the State and sometimes to the accused. I would suggest, as a prevention of such unfortunate mistakes, that a commission be appointed by the court, to serve for a period of not less than two years, whose duty it should be to examine all cases, in their jurisdiction, charged with insanity. Such a commission would take more time and care to thoroughly inform themselves, thus becoming better experts on the diseases of the mind; they would the more certainly exact justice and right to all concerned." The true expert in cases of insanity is a diagnostician—nothing more nor less. His claim to respect and credence is in exact proportion to his exhibition of scientific knowledge and honesty. The medico-legal study of crime has, in the past few years, opened up a new field, and properly claims the thoughtful and serious attention of the legal profession, as well as the medical student and jurist. Some plan should be formulated for the most thorough, conscientious study and investigation of the cause of crime other than those due directly to a sudden impulse of passion or fit of anger, homicidal mania, or alcoholic intoxication. The prison population of this country is exceedingly, if not alarmingly, large, and while there is no doubt it is as carefully cared for with regard to shelter and food as in any part of the civilized world, yet there is but little being done to study and, if possible, know the etiology and pathology of the prodigious abnormalities of criminal conduct. To a proper investigation of this subject, questions like these have suggested themselves: Where have these unfortunates come from? How far are they unfortunate—the victims of adverse circumstances? How far the subject, or sufferer, of actual disease—acquired or hereditary? What, under the most favorable view, does life hold in store for them? To suggest a method or plan for a careful study and investigation in this new field is a matter of considerable difficulty. But, through the combined wisdom of this Society, a formulated plan may result that will ultimately be for the good of the unfortunate—the criminal portion of our race—and the benefit and peace of communities.

Dr. C. G. Kuhlman, of San Francisco, said he was sorry that this paper had been read, as the report of the Committee on Medical Jurisprudence, as there was in it only one point appertaining to that subject, and that was insanity. All the rest of the report, appertaining to hygiene and sociology, were certainly not parts of so-called medical jurisprudence or forensic medicine. The speaker then entered, at considerable length, into a review of the field of forensic medicine, which he said was an immense one, and worthy of more attention than it had received at the hands of the profession. It was humiliating to see leading men in the profession, when testifying as experts, utterly discomfited by some tyro in the law. In concluding, the speaker said: The history of forensic medicine is a most interesting one, and it has been the life-work of some of the greatest men in the world. Galen wrote upon seven months pregnancy, and upon simulated diseases. Turning to Rome, we find that the twelve tables fix 300 days as the extreme duration of utero-gestation. In the Justinian laws we find various subjects enumerated. In 1665 commenced the dawn of forensic medicine in Rome. I should like to have occupied more of the time of the Society, and to have called attention to some of the works written at that time, so as to infuse into you the proper enthusiasm on this subject. As I have already said, medical men are often discomfited on the witness-stand; and it is a shame that members of a profession whose object is the amelioration of the condition of humanity, and whose minds are peculiarly adapted for scientific investigations, should go on the witness-stand and be defeated on their own ground. I hope what I have said now will stimulate you to a thorough investigation in that direction, and that you will elevate forensic medicine to the position it ought to occupy.

Committee on State Medicine, Hygiene, and Adulteration of Foods and Drugs.—M. M. Chipman, of San José, the chairman of the committee, said: The moral code, as now generally accepted among christian nations, is in perfect accord with man's physical requirements, and is, therefore, in accord with the laws of hygiene; whilst immorality is discordant, and all immoral practices are anti-hygienic, and tend to bring about a diseased condition of the body, and are also subversive of the intellectual powers of man's mind. If individual immorality spreads until a large proportion of a community becomes involved, a lack of public hygiene will soon become manifest, and unprosperous conditions will prevail. If a nation becomes corrupted, so that immorality generally prevails, that nation has placed itself upon the broad road to ruin, through decadence and weakness of the body politic, as witness the rapid decadence of the ancient nations of Babylonia, Assyria, and Persia, immediately after their subjugation, in succession, by other powers, and also of Egypt and other nations, the rise and fall of which are traceable in history; and in the later centuries of Greece, and following that of Rome; all of which bear witness that in morality and virtue are the elements of strength and vitality, whilst immorality and vice constitute the greatest factor of the elements of weakness and decadence. Moral principles and moral and virtuous lives, as taught and exemplified by Zoroaster, Moses, Confucius, Gautama (the Buddha), Socrates, and Jesus, have been always accompanied by progress, development, and advancement in civilization, whilst immorality, and especially in matters pertaining to the generative functions, either individually or on the broader scale of nationality, has always led to retrogression, has tended towards barbarism and disintegration, as witness the present state of the Mohammedan population of Asia and Africa and the Turkish empire; results of the propagation of the principles and practice of polygamy, and the example of the founders of that faith. The history of the Teutonic race is traceable for 5,000 years, from its ancient home, as a branch of the great Aryan family of Mesopotamia. This race has been most persistent in its adherence to the principles and practice of morality, and reverence of virtue and chastity; and whilst its development in the past history has been less rapid than that of some other races at times, it has still continued steadily progressive in its evolution. At present it is represented by three nationalities, which take rank among the foremost powers of the earth. In Germany, the fatherland; in Britain, by the Anglican branch, and in America, as the off-shoot of the Anglo-Saxon development. Taken together, those three representative nations control more of the earth's surface, exercise a greater influence over the world's affairs than any other race; and if combined would present a greater naval and military power than has ever been developed by any other race within the domain of history. All this has been accomplished through the firm adhesion to the principles of morality and virtue. Will this progress in development in culture and advancement onward continue? If these nations continue in the same paths of integrity, morality, and virtue, then progress will continue, and especially will the United States, with its comparatively virgin, undeveloped and immense resources, continue to multiply in its numerical strength, and increase in national power. But a dark cloud appears flitting across the horizon of its future, through the introduction of comparatively new and subtile methods of the infection and spread of vice, by the teaching of false principles of physiology and of morality and of false aspects of virtue, which bode evil to the nation. This should be met and arrested by more special, by wider and more extended education upon the subjects and science connected therewith, so that the public, and especially the rising generation, may become enlightened and warned of the encroaching evil, and learn to check and stamp out this greatest menace to the prosperity and future progress and power of the republic.

EVENING SESSION.

Committee on Ophthalmology and Otology.—Wm. D. Babcock, of Los Angeles, chairman of the committee, took for his subject, "Tansley's Cut to Avoid Mastoid Trouble." He said Schwartz, in 1868, recommended paracentesis of the membrana tympani in acute inflammation of this structure, accom panied by great pain, where the usual remedies cannot relieve. It has been shown that a very little swelling of the tympanic mucous membrane will shut off the upper part of the drum cavity from the lower. Clinically, it is true that inflammations of the lower part of the drum cavity with perforation do well with little or no treatment, while in inflammations of the upper cavity we have the long-persistent, suppurative processes that are difficult to control. The inflammation being confined to the upper posterior segment, the tension increases, and, as the roof of the cavity is bony, the yielding tympanic membrane bulges outward. The muco-periosteum becomes loosened from the bone, the inflammatory process extends in all directions, but mostly along the upper and posterior part of the external meatus. Having thus a true periostitis, the indications are plain: relieve the tension. Most writers say, puncture only. Pommery advises an incision not over one-eighth of an inch in length. Dr. J. O. Tansley, of the Manhattan Eye and Ear Infirmary, advises the use of a Graefé's iridectomy knife, making the puncture in the upper and posterior quadrant, and pushing the knife in until you feel the bone in the rear wall of the tympanic cavity. Then depress the handle, and cut outward for at least three-quarters of an inch, keeping the point of the knife on the bone all the time. In every case denuded, rough bone will be found. The speaker said Dr. Tansley's claim, in which he fully agreed, was, that invasion of the mastoid cells could, in a large number of cases, be prevented by this free incision. From personal experience he could testify to the ease of making the cut, the relief of pain and the arrest of pus formation.

Irregular Astigmatism.—E. S. CLARK, of San Francisco, said "Mixed Astigmatism" would have been a more exact title for his paper. He used the term advisedly, as the cases recorded were certainly not corrected by a sphero-cylindrical glass, as all cases of compound and mixed astigmatism may be. It is a well-known fact that any combination of cylinders may be reduced to an actual sphero-cylindrical equivalent, but it can also be shown that, in the greater number of cases, sphero-cylindrical glasses cannot be ground equivalent to the combination of cylinders; and, further, it often happens that a patient, if the ametropia be very slight, can easily be fitted with two cylinders at various angles when the nearest approximate sphero-cylindar will not be accepted. The speaker then gave a series of twelve cases, showing the amount of refraction, the glasses used to correct it, and the results obtained.

Suggestions Regarding Treatment of the Ears and Throat in Children.—M. C. O'TOOLE, of San Francisco, said he intended to address the general practitioner, rather than those engaged as specialists in the treatment of these organs. This is essentially an age of prophylaxis and of preventive medicine. Credé, by the introduction of his method for the prevention of acute blenorrhea, is little less a benefactor to humanity than is Jenner by the discovery of vaccination. He proposed to show that the gonococci, bearing maternal vaginal secretion, which, during parturition, is the etiological factor of acute blenorrhea in infants, is occasionally, under like conditions, conveyed to the nasal cavities and middle ear of the new-born. Owing, however, to histological dissimilarity of the structures involved, the inflammatory process is less intense and less rapid in disintegrating influences than the inflammation of acute blenorrhea. All observers agree that acute inflammation of the middle ear is a disease of very frequent occurrence in infants and in older children. It is now generally recognized that an acute catarrhal inflammation of these structures frequently passes into the suppurative form. Statistics are given to show the relative prevalence of this disease, as compared with ear diseases generally. Roosa questions the accuracy of these statistics, and says the advance of otology has been greatly hindered by the notion quite prevalent in the profession, as well as amongst the laity, that the nurse or mother is fully competent to treat an acute aural disease, while a physician, and perhaps a specialist, is needed, when it becomes chronic. It will thus be seen that statistics as to the prevalence of acute inflammation of the middle ear are, of necessity, inaccurate and unreliable. Regarding the etiology of the disease in question, we possess no positive knowledge. He then quoted from recent writers in support of this position, showing that the opinions of the authorities were neither definite nor unanimous. The acute cases, when neglected, are recognized in the later years of the victim as belonging to that usually hopeless condition known as chronic non-suppurative imflammation of the middle ear, or, possibly, as a case of acquired deaf mutism. More than 50 per cent. of deaf mutes belong to the class just mentioned. In this form the essential structures of the function of hearing must have been destroyed between birth and that time when the infant becomes old enough to imitate speech, or when, say, 18 months old. It can be safely stated that to accomplish the disintegration necessary to destroy the essential organs of hearing on both sides within the time specified, it would require a more potent, a more violent contagium than can be found in any form of simple catarrhal secretion. Five years ago he had removed adenoid vegetations from the phryngeal vaults of three children, all of the same family, aged at the time 3, 5, and 6½, respectively. The mother of these children mentioned, incidentally, that she had suffered considerably with the whites, and had been so affected at the time when each of the children was born. She was then 6 months pregnant, and her attending physician being out of town, he introduced to her a *confrère* who was then engaged to attend her. At the speaker's request he remedied the abnormal vaginal secretions. The infant was born and is now three years old, and has no abnormalities of the pharyngeal vault. Since then the speaker had invariably questioned mothers having children with these growths, and had as invariably ascertained that they had been affected with abnormal vaginal secretions at the birth of the children. He had, therefore, formed the opinion that acute suppurative inflammation of the middle ear in infants is, in most cases, the result of contact with gonococci bearing, vaginal secretions during parturition, and that catarrhal secretions are, under like conditions, responsible for the abnormal lymphatic follicles and adenoid vegetations found in the pharyngeal vaults of older children.

Purulent Ophthalmia; Legislation Against.—W. F. SOUTHARD, of San Francisco, said he had not written a paper, but he desired to present a few ideas on legislation for the prevention of this trouble. In 1887, Dr. Howe, of New York, first took up the subject of legislation for the protection of infants, we might as well call it, on account of the vast number of cases of blindness due to ophthalmia. In the United States we have somewhere about 60,000 blind, of which perhaps 10 per cent. are due to ophthalmia. At the present day this is a disease that is easily and quickly checked and cured if it is taken in its earlier stages. Under modern methods of treatment there need not be any cases at all. We know, from the statistical material that has been given us from abroad and at home, that where, under the old methods of treatment, or no treatment at all, the number of cases of blindness rose, in some institutions and lying-in hospitals, to 8 per cent., and this has been reduced to less than 1 per cent., under modern methods of treatment. It is in the interest of the children that this legislation is proposed. In New York, in Maine and in Rhode Island, legislation has been enacted, compelling nurses, midwives, and all who are engaged in the care of infants, under penalty, to report to the health officer within 10 days after birth if they notice any discharge from the infant's eyes. We find 10 per cent. of all cases of blindness that could have been prevented, and it is a disgrace and a crime that such a thing should exist. We ask that this Society endorse the action of the Society of Eye, Ear, Nose and Throat Specialists in endeavoring to have a law enacted or proposed at the next session of the legislature. It is an economic question. When you think of the vast amount of money expended in this country every year for the support of the blind, whose eyes could have been saved in infancy, we have a question that immediately appeals to every individual, at least to every tax-payer. The nurses and midwives having charge of such cases, having a knowledge of such a law, would conform to it, or ought to; and will, under penalty, do so. It will give them a greater feeling of responsibility. Parents, of course, are interested because they don't care to have their children blind if it can be prevented, and they will take an interest in employing only such nurses and midwives as have some knowledge of the subject. Every one present knows what ophthalmia is, and how rapidly it spreads, and how rapidly a child's eyes are irretrievably lost if it is not quickly taken in hand. It is a form of legislation that can be easily carried out, and the law can be enforced if everybody is interested in it, and when parents understand the gravity of the disease.

DR. A. BARKAN, of San Francisco, then read the following proposed law:

The People of the State of California, represented in Senate and Assembly, do enact as follows: SECTION 1. Should one or both eyes of an infant become inflamed, or swollen, or reddened, at any time within two weeks after its birth, it shall be the duty of the midwife or nurse having charge of such infant to report, in writing, within six hours, to the health officer, or some legally qualified practitioner of the city, town or district in which the parents of the infant reside, the fact that such inflammation, or swelling, or redness of the eyes exists. SEC. 2. Any failure to comply with the provisions of this Act shall be punished by a fine not to exceed two hundred dollars, or imprisonment not to exceed six months, or both. SEC. 3. This Act shall take effect on the .... day of ...., eighteen hundred and ninety.......

He said the law has been carefully framed, and if the endorsement of this Society could be obtained, he thought there would be no difficulty in securing its passage. The bill was referred to the Executive Committee.

Lesions of the Lachrymal Passages and Nasal Duct.—H. I. JONES, of San Francisco, said, in order to avoid prolixity, he would present his subject in a general way. Common eye disorders are now receiving far more attention than at any former period. The day is approaching when, by early diagnosis and treatment, their disastrous sequelæ will be greatly diminished both in number and in severity. The lachrymal apparatus comprises the gland with its excretory ducts, the puncta, the canaliculi and lachrymal sac and nasal duct. An intimate relation exists between the conjunctiva and the schneiderian membrane through the medium of the vasa motor and sympathetic nerves. Irritation of the ocular mucous membrane is reflected to the nasal mucous membrane, and *vice versa;* therefore in all eye cases it is requisite to examine the nose carefully. Disease in these parts may result from conjunctivitis, nasal catarrh, exposure, and injury. No case of watery eye should be lightly dismissed with some placebo as being of a trivial nature, only to be seen again when it has developed into a well marked mucocele. In every case a careful search should be made for any conjunctival disease, when the patency of the puncta should be ascertained, and also that the position of the lower lid and of the punctum is normal. Inflammation of the conjunctiva and canaliculi, whatever its origin, may extend to the lachrymal sac and excite a dacryocystitis, which is at first catarrhal and subsequently becomes purulent, or the course of the disease may be in a reverse direction. All cases of epiphora should have prompt attention, the object being to restore the parts to as nearly a normal position as possible. The most satisfactory treatment is by using antiseptics and astringents, and probing less frequently. The speaker said he was sure that those who had had any experience in these cases would bear him out that the most chronic and obstinate were generally due to meddlesome surgery rather than to the original disease. When the seat and anatomical relation of the tear sac are kept in view, the diagnosis and treatment is easy. If nothing is found externally, and if no mucocele is present, it will be necessary to ascertain the patency of the lachrymal sac and duct by injecting a 4 per cent. solution of cocain through the canaliculi. Should the fluid pass into the nose a rapid cure is certain. A few injections of sulphate of zinc, 2 grains to the ounce, or bichloride solution (1:5000) every two or three days, postponing the radical treatment of any stricture that may be found until this has been repeated at two or three sittings. If it be necessary to pass a probe, a Bowman No. 2 or 3 would pass through the punctum and canaliculi without any division of the latter, after first painting the part with a 10 per cent. solution of cocain. When the sac has become dilated probing should not be resorted to until a complete obstruction has been shown to exist. In cases where there is a syphilitic history we should not resort to operation until internal medication has been faithfully tried. Ophthalmic surgeons are too prone to slit up the canaliculi, and to incise a stricture in these cases. In many of them all signs of obstruction and inflammation in the duct disappear after a course of specific treatment. The speaker said he saw daily in private and in dispensary practice cases in which ocular symptoms were not relieved by medication directed towards the eye and the lids, but which disappeared almost completely under nasal treatment. If a stricture of the nasal duct exists it will be necessary to operate, and probes will then have to be passed daily to prevent the wound in the canaliculi from healing up, and also to gradually dilate the nasal duct. Sometimes cases are encountered where from chronic ophthalmia the lower punctum has been displaced, so that instead of facing towards the eyeball it is directly upwards and forwards. In such a case the tears will run over the edge of the lid, and our object will be to transfer, as it were, the displaced punctum to a position where it can collect the tears.

Dr. M. C. O'Toole, of San Francisco: The gentleman who has last spoken referred to syphilitic obstruction of the lachrymal passage. Now, I dare say that such conditions may exist, but that they should be an isolated condition. That we would not have other symptoms to guide us to treat it according to requirements would be very exceptional, indeed. The obstruction of these passages may be found in the superior turbinated body. My method of getting that free is not original. Put a particle of chromic acid on a probe and put it around the opening. This is better than all the probing above.

Dr. C. G. Kuhlman, of San Francisco: I cannot agree with Dr. O'Toole in regard to the extension of the process through the middle ear causing deaf-mutism. There is absolutely no scientific data to justify any assumption of the kind. On the other hand, we have scientific data which thoroughly explains the cause of deaf-mutism. These consist of 212 pathological specimens, now contained in the Medical Museum of Copenhagen, which have been prepared from time to time by the surgeons in charge of the Deaf Mute Hospital there. They are the most perfect specimens, and the only ones, in existence to-day. They are complete in detail, and the history of the patients is with them. According to these data, it is shown that deaf-mutism depends upon an abnormal condition of the ear itself, and that in all these cases the patients ultimately died from tuberculosis. In most cases it was due to an insufficiency of the aural apparatus. With these statistics before us, I do not think that we are justified in assuming that deaf-mutism is caused by an extension of the blenorrheal processes through the middle ear. In regard to Dr. Jones' paper, I wish to say that it has been my good fortune to have four cases come under my observation and treatment. Three of them were caused by traumatism. The cause of one was unknown. In these cases I caused a radical cure by evacuating the pus, and injecting a one-in-three solution of iodine, causing a permanent cure, with no recurrence of the secretion.

Dr. O'Toole, of San Francisco: I would simply state for the gentleman's information, that it is an acknowledged fact—not my *ipse dixit*—but the acknowledged fact the world over by writers and students of otology, that 50 per cent. of all deaf-mutes at the present day belong to the acquired form; that is, the form that is acquired between birth and the age of 18 months. The malformations and intro-organic uterine derangements make up the rest. Professor Baird and Dr. Roosa examined 296 cases, and in only 50 of these did they find the ear passages, including the membrane and tympanum, in a normal condition.

Dr. A. Barkan, of San Francisco, said: Eight or nine years ago he had examined all the inmates of the Berkeley Asylum for the Blind and Deaf and Dumb, and that possibly one-third of all the children examined by him had acquired the deaf-mutism at some time after they were able to hear, and before they had been able to talk. Parents generally answer in the affirmative, when asked if their baby was ever able to hear. Such statements must be mistrusted. I dare say you have all seen the disastrous effects of scarlet fever and diphtheria upon the middle ear of children three or four years of age. In those cases it is simply an interruption of the communication of sound waves from the outer world, which causes loss of hearing and then loss of speech, and ultimately deaf-mutism. In about two-thirds of all the cases, so far as ascertained, deaf-mutism was congenital. I think probably the truth lies somewhere between the statements which have just been made.

Dr. H. I. Jones, of San Francisco: In severe cases, where the secretion becomes purulent, I believe in radical treatment.

Committee on Laryngology and Rhinology.—The report of this committee was read by the chairman, A. Barkan, of San Francisco, who gave a review of the therapeutic progress in rhinology and laryngology in 1893. In removal of the pharyngeal tonsil, complete and thorough removal of the growth has to be accomplished in order that, whatever precautions are taken, when once anesthesia has been induced, as little additional as possible of the anesthetic should be given. Dundas Grant strongly recommends nitrous oxide gas as the safest anesthetic in these cases. Butlin favors chloroform, as permitting the patient to be kept longer under its influence. Among English authorities the use of a general anesthetic is almost universal, but at several large clinics on the continent this is entirely dispensed with, cocain being considered sufficient for the requirements of the operation. The speaker regarded a general anesthetic as dangerous and superfluous when taking into consideration the brief pain; on the other hand, the application of cocain appeared to be insufficient. The proper treatment of the remaining general thickening of the mucosa of the naso-pharynx is swabbing with Lugol's solution. This, which is now being used extensively, consists of—

Iodine	gr. vi
Iodide of Potass.	gr. xii
Ol. Menth. Pip.	m. xii
Glycerin	oz. 1

Operations in this region are not to be lightly undertaken, and that every safeguard must be adopted impresses itself more and more upon us, as cases of fatal hemorrhage are recorded. Up to the date of the publication of his case in THE MEDICAL TIMES [vol. viii, p. 118] five others have been recorded, In the treatment of tonsillar disease, hypertrophy, with recurring acute attacks, must be submitted to the guillotine or to the galvano-cautery. In adults the latter method appears to be gaining ground, especially in cases of modern hypertrophy. An interesting innovation is that of Dr. A. Ruault; he advises partial ablations and immediate iodized applications as superior, and as giving rise to scarcely any bleeding. It is superior to igni-puncture, being less painful and without reaction. Dr. John MacIntyre, in his presidential address at the annual meeting of the British Laryngological Association, speaks of the action of antiseptics in diseases of the upper respiratory tract, especially when it is desired to attack a local focus of inoculation, as in the false membrane of diphtheria, a difficulty arises in the crypts or cavities which do not permit the efficient action of the germicide. He has, for some years, been in the habit of excising the tonsil in acute affections, seeing that the raw surfaces were frequently and carefully attended to, and the result has proved satisfactory. The several pathological states of the lingual tonsil are receiving attention. Daily applications of Lugol's solution are mostly relied on. The use of the cautery in this dangerous region is warned against, from the fact that perilous hemorrhage and acute glandular swelling in the cervical region have occurred. The speaker briefly referred to the use of massage in the treatment of hypertrophic, atrophic and neurotic forms of disease in the upper respiratory passages. Pharyngitis has also made better progress under massage. The newer application of electricity in the nasal region were mentioned, and the speaker said that electrolysis had here a fair field. The use of the vasogenes was mentioned, Klever's manufacture being considered the best. These are pure hydrocarbons impregnated with oxygen, and there are many combinations; the principal, including menthol, iodoform, eucalyptus and creasote were mentioned. In all catarrhal diseases of the respiratory membranes, antipyrin, in a spray of from one to four per cent., is one of the best local analgesics and anti-spasmodics. In nasal hemorrhage trichloracetic acid, one part to thirty or forty of sterilized water, with the addition of a small quantity of cocain, is highly recommended as a hemostatic. Regarding treatment of the diseases of the larynx there was nothing radically new. In tuberculous ulceration of the larynx the best local application is a 20 to 80 per cent. solution of lactic acid. The surgical treatment of laryngeal tuberculosis has become the most important. Curettement is very serviceable, especially where the infiltrations are well defined, localized and of slow development. The therapeutic summary of laryngeal tuberculosis is lactic acid locally, curettement, creosote internally, improvement of the general condition, and change of climate.

Disease is Not Inherited.—THOS. F. RUMBOLD, of San Francisco, in a paper under this title, devoted himself mainly to the baneful effects of the theory of heredity and to disapproving its current belief. The affirmative of this theory has been assumed for ages, and it is an idea of the laity with which the profession coincided. He then cited several cases of different diseases, most of which apparently supported the theory, yet were only evidence of our inability to trace the connection. Many of the so-called inherited diseases, such as consumption and syphilis, are acquired by contact. The speaker said instead of asking a man who applies for life insurance, "Did your father or mother die of consumption?"

he should be asked, "Is your wife or any member of your family now suffering from consumption?" His father or mother might both have died of this disease, yet he may live to old age; but if his wife or a beloved child is suffering from it he is almost certain to contract the disease, and to die from it within seven years, unless he maintains his health in the best possible condition. To prove that syphilis is not inherited is a very difficult task, for the reason that the facts and the evidence cannot be fully obtained. The speaker then cited cases of this disease that illustrated his position, and concluded by giving some facts from histology in relation to cell life. These went to show that as the influence of heredity comes from within, while every effect producing unfavorable results comes from without, the logical deduction was that disease is not a consequence of the indwelling and inherent properties of the body, but that the efficient cause of disease is always external.

Dr. M. C. O'Toole, of San Francisco: In regard to the last paper, it does not come within the scope of this committee. It is an abstruse physiological question, and I will leave it to its merits. I am glad to have the opportunity of corroborating many of Dr. Barkan's statements, but I will coufine myself to a very important subject that is occupying the attention of rhinologists and laryngologists and of surgeons everywhere. I refer to the pharyngeal tonsil and its removal. That is the name that Luschka has given it, and I propose to know it by that name. What its physiological structure may be is another matter. After fifteen years' work on these structures, I contend that there is no necessity of an anesthetic, or of tying the patient. I have in over 4,000 cases taken them out in 10 seconds, and I do it every day. There is not a week that I do not remove from 10 to 12 of these growths from children; and wherein comes the necessity of running the risks of allowing the secretions to pass down into the larynx, as they have been known to do, and of punishing that patient with any form of anesthetic, is a mystery to my mind. I have cultivated my right finger-nail for this last fifteen years, and I can cut within 10 seconds the whole of these formations, not alone from around the plane of the surface of the cavity, but around and within the orifices. Lennox Brown, in his late work, says, with emphasis, that a well-educated finger-nail is all that is wanted up to the time the child is 7 years old, and after that we seldom see them. You can cover the nail with the finger of a glove. You must not let it be broken. I am glad to have the opportunity of asserting, as I do, the absolute inconsistency of using any of these manipulations, and of passing into the oral cavity of a child a cutting instrument. I have promulgated, I believe originally, to-night that leucorrhea, neglected and aggravated forms of abnormal secretions, is the cause of abnormal lymphatic formations in the vault of the pharynx.

Dr. C. G. Kuhlman, of San Francisco: There seems to be an error that we all fall into which is the outgrowth of ignorance, if I may so term it, which causes us to operate in acute tonsilitis. Galen performed tonsilotomy in a crude way, perhaps. He laid down the maxim, which was based on physiological and pathological laws, that we should not remove the acutely inflamed tonsil, because in that condition the vessel walls are diseased and incapable of contraction. Hence the danger of hemorrhage. If the tonsil is too large, or remains enlarged after it has passed into the chronic state, then we may remove it with safety, because the vessel walls have resumed almost the normal physiological capacity for contraction. I think that all cases of hemorrhage after tonsilotomy are due to the fact that the surgeon operated in cases of acute tonsilitis, where not only the walls of the tonsilar artery are acutely inflamed and incapable of contraction, but the process has extended to the carotid also. In regard to the use of hemostatics, Dr. Barkan has omitted from his therapeutic vocabulary the most valuable in the whole materia medica, sulphate of copper. I have seen no case—and I have treated many cases—of acute tonsilitis, that did not readily yield to the application of strong solutions, acrid solutions of sulphate of copper. Nor have I seen a case of nasal hemorrhage that did not yield to the hemostatic effect of strong injections of sulphate of copper. I have had several cases lately, where plugging failed. I have removed the plug, and injections of a strong solution of sulphate of copper had the desired result in a very few minutes. In regard to Dr. Rumbold's paper, I have laid before you this afternoon some statistics by Bang and Gartner appertaining to their researches on inherited tuberculosis which demonstrated that tuberculosis is inherited *in utero*. I will not dwell upon the philosophic deductions that the doctor arrived at, but they certainly can be gainsaid upon the same ground. There is no question that an organism, without inheriting the taint, is capable of becoming diseased by a lowering of its physiological resistance or by a lowering of the physiological resistance of its histological elements.

Dr. A. Barkan, of San Francisco: It is very evident that Dr. O'Toole means every word he says, and I have no doubt that in his experience the finger-nail, armed with a nail of the proper length, and, I will say, a nail of the right density and force, has accomplished all that he maintains. I am far from saying that it will not accomplish a great deal in many cases—all that is to be desired, but I am more catholic, and say other things will accomplish the same. Gottstein's curette, as I have demonstrated at a former meeting, is a simple ring knife; it is smooth in all its upper surfaces, the outer ring being smooth. I consider it as safe an instrument to use as the finger-nail, or as any other instrument. So may the forceps be used. I think that occasionally severe hemorrhage will occur, no matter what instrument may be employed. I know of one case where very severe hemorrhage was produced by a mere examination of the naso-pharynx with the finger. Whilst I will admit the possibility of removing the growth with the finger-nail in many cases effectually, in my experience and in the experience of many others, it is not efficient. The most important part of it is that we should recognize the presence of a pharyngeal tonsil; that there is an obstruction of the breathing, which retards the oxygenation of the blood and the development of the chest. The disease is a very prevalent one, and I hope that our experience will show us better and safer ways of dealing with it.

Dr. T. F. Rumbold, of San Francisco: I wish to endorse Dr. Barkan's recommendation of operating in cases of acute tonsilitis when the tonsils are very large, so as to threaten asphyxiation of the child. In 1881, in the International Congress, there was quite a dispute between Lenox Brown and McKenzie, as to who first operated, and I believe they both operated about the same time. Before coming to California, I operated on seven or eight patients, successfully. Only a small portion of the tonsil was removed, and it was not followed by great hemorrhage nor difficulty in breathing, and it at once relieved obstruction in the throat. I think the removal of that growth called Luschka's tonsil with the finger-nail can be done in some persons; in persons who are not more than 10 years of age, I think it can be done well and quickly, but if you are not careful you are very apt to leave strings behind, and every one of those strings will make another growth. In using Gottstein's scraper, if you are not careful you will leave some strings. The principal thing to guard against is the return of the disease. I have seen a great many return after operation. I think the heredity of tuberculosis is going by the board. All bacteriologists nowadays say that the disease is caught.

SECOND DAY.—WEDNESDAY, APRIL 18.—MORNING SESSION.

Report of Secretary.—The report of the Secretary, W. Watt Kerr, of San Francisco, showed that there were 359 active members on the roll of the Society. During the year 4 members had resigned and 11 had been dropped for non-payment of dues.

Report of Treasurer.—The report of the Treasurer, J. H. Parkinson, of Sacramento, showed that he had received during the year $1,794.65, and disbursed $2,061.65. The amount of cash on hand was $2,671.71.

Report of the Board of Examiners.—This report was read by the Secretary, C. C. Wadsworth, of San Francisco. The number of meetings held during the year was 12; original certificates granted, 256; additional certificates, 1; applications refused, 5; applications withdrawn, 9. The report of the Treasurer of the Board showed that the total receipts for the fiscal year, there being no balance shown from the previous year, had been $2,306.00; the total disbursements being $2,306.00. The receipts showed that the revenue from advertisements in supplemental register and sale of copies of registers had been $961.00, and from applications for certificates, $1,345.00. With this income the Board had been able to publish a supplement to the Official Register, and to pay its expenses, including salary of Secretary, "extra clerical labor," and its attor- fees without reporting a deficit. This, which is a marked improvement on former years, is highly to be commended. As a step toward a still higher educational requirement the Board, at its meeting of March 10, 1894, adopted the following resolution, to go into effect on and after September 1, 1896:

Resolved, That the words, "Medical institutions in good standing," in Section 3 of that certain Act passed by the Legislature of the State, approved April 3, 1876, and entitled "An Act to regulate the practice of medicine in the State of California," is hereby defined to include only those institutions which require at least four regular courses or sessions of six months each, extending over a period of four years for graduation.

The report concluded with an opinion, by its attorney, on the legality of a method proposed for the election of the Board of Examiners. For many years this election has been a source of trouble, and on one occasion it occupied about three hours of the afternoon session. The proposed change was to the effect that the seven candidates receiving the highest number of votes cast should be declared elected Examiners; the three next highest being declared the alternates. The attorney, Dr. S. R. Taylor, fully reviewed the question, and gave as his opinion that the proceeding was perfectly legal. He suggested that, to avoid complications, it would be best to hold separate elections for Examiners and for alternates.

DR. H. BERT ELLIS, of Los Angeles, introduced the following resolution: WHEREAS, The Medical Society of the State of California views with pleasure the approaching meeting of the American Medical Association in San Francisco; and whereas, it has been the universal custom in other States to tender to the Association, under the supervision of its Committee of Arrangements, an elaborate entertainment in the name of the profession of the State; now, therefore, be it *Resolved*, That this Society hereby appropriates from its treasury the sum of twenty-five hundred dollars, to be used in the entertainment of the American Medical Association, under the supervision of its Committee of Arrangements; and the Treasurer of this Society is hereby authorized and directed to pay said twenty-five hundred dollars to Henry Gibbons, Jr., Chairman of the Finance Committee, for this purpose.

San Francisco Medico-Chirurgical Society.—H. H. HART, of San Francisco, offered the following resolution, which was referred to the Executive Committee:

Resolved, That the Medico-Chirurgical Society of San Francisco, having adopted the Code of Ethics of the American Medical Association, is hereby recognized as a regular medical society in good standing within the meaning of Section 5, Article I, of the Constitution of this Society.

Committee on Obstetrics and Puerperal Diseases.—The report of this committee (published at p. 258) was read by the chairman, H. H. HART, of San Francisco, the title being "The Management of the Third Stage of Labor."

Puerperal Fever.—In the absence of the author, P. M. LUSSON, of San José, this paper was read by the Secretary. The writer said there was no affection that so excited feelings of sympathy as this disease. The patient having passed safely through all the dangers of child-birth was now confronted by a greater danger. He wished only to present the result of his observations during many years of practice, which he believed would be of some importance. The author then stated that there were several types of the disease that should be specifically designated, as they in each case demanded different treatment. He firmly believed there was a specific puerperal fever, or, as he had once called it, a typho-puerperal fever, sometimes beginning before confinement, which was undoubtedly infectious, and usually fatal. It occurred in spite of antiseptic precautions, and might appear in a perfectly normal case. Fordyce Barker maintains that it is an essential fever and not the consequence of any local lesion, but a modification of the general organism antecedent to the local conditions. While many authorities did not agree with this view, it was difficult, otherwise, to explain cases that began before parturition. In Europe there were those who believed that there was sometimes something more than septicemia, and Pasteur, who had studied the germs of the febrile process, had stated that the infection was not always the same. The author then entered into the symptoms and course of the various types of the disease, and said that all were caused by an infectious *materies morbi*, which had been fully demonstrated by Pasteur. This could be communicated through the air, from the clothing, or by the hands or instruments of the operator. Attention should, therefore, first be directed to the existence of any preëxisting condition which should be remedied, and next to the avoidance of any unnecessary interference with the natural process of labor. In Vienna, and in other lying-in institutions in Europe, before prophylactic measures had been adopted, the mortality was from 5 to 10 per cent; now it had fallen to less than 2 per cent. Perfect cleanliness and the use of antiseptics were the essentials. He preferred carbolic acid, which he had found effectual and far safer than the bichloride of mercury. Avoid introducing the fingers into the uterine cavity, and do not hasten the delivery of placenta so as to remove it before it has become detached. His rule is to wait 15 or 30 minutes unless there was too much flowing, when he gave ergot. He had followed this practice during the past 20 years, and had good reason to be satisfied with it. In 743 labors he had only lost 4 cases from puerperal fever, and 3 others from complications following pelvic deformity or instrumental delivery. Regarding prognosis, he felt that in this disease, as in typhoid fever, as long as there was life there was hope. In treatment, he believed in the early and free evacuation of the bowels, and he observed that those cases in which a free action was maintained did best. He used quinine, and used it freely. An intrauterine injection was given early, and if fetid lochia indicated retained debris the curette should be employed. Vaginal irrigations, with carbolized water, should be given once or twice a day, as needed.

DR. W. F. CHENEY, of San Francisco: I would congratulate Dr. Hart upon selecting one subject instead of attempting to review the whole field of obstetrics and puerperal diseases. He has selected a practical and important subject in the management of the third stage of labor, which comes at a time when not only the patient, but the physician, is really exhausted, perhaps, by a long delay through the first stage, and by the active work of the second stage and the delivery of the child. The physician is exhausted, and on that account he is apt to slight his work and leave undone that which ought to be done. In regard to the general question, how the placenta shall be treated, how the third stage of labor shall be managed, there are two views: the expectant method, which is applied by the Germans, and the subsequent immediate delivery of the placenta, as approved by Credé. The question whether the placenta shall be delivered immediately or not resolves itself into the effect of delay upon the patient. It seems reasonable, all things considered, that if there is no hemorrhage following labor, and if the patient is not suffering, it is advisable to wait for a reasonable length of time before taking away the afterbirth. On the other hand, it is true that as long as the placenta remains within the uterus there are two dangers: hemorrhage and septicemia. We therefore must steer between these two methods. It will not do to remove the placenta too soon; it will not do to wait too long. The rule laid down by Dr. Hart seems a good one—to wait at least 15 minutes. The plan proposed by Alfeldt is to wait at least 2 hours; but investigators who have pursued Alfeldt's method of waiting 2 hours, and have preserved statistics of their cases, show that the loss of blood is always greater by waiting this length of time than by waiting 15 minutes, and, consequently, the subsequent history of the case is not favorable; the woman does not get up in good condition. The proper plan seems to lie between the two extremes, and the plan of immediate extraction is only resorted to when there is some indication for it. If there is profuse hemorrhage, then there is no question about delay. I am glad that Dr. Hart has spoken about traction upon the cord as a means of releasing the placenta, because in the works on obstetrics this plan is decried. We are told that we must not make traction upon the cord. I remember that in my student days this was impressed upon me, and in one of the first cases I had I was troubled to get the placenta out. I waited a reasonable length of time, and then sent for a gentleman, in consultation, under whose instruction I had been. In a very few moments he had the placenta out, and I said to him: "Doctor, how did you do that?" He said "I made a little pressure upon the uterus, and I made a little traction on the cord, and it was out." In justice to this gentleman, it should be said that at the present time he teaches traction upon the cord as a method of releasing the placenta. No harm can come from moderate traction upon the cord. A man who is brutal and uses undue force can undoubtedly tear a cord loose from the placenta, or he can tear loose the placenta from the uterus before it is fully separated, leaving portions of it behind; but it seems to me that moderate traction upon the placenta from below, in the axis of the uterus, is a more rational plan of procedure, and less apt to result in danger, than undue force from above, crowding the uterus down into the cavity of the pelvis, and compressing it extremely, as is often done. In regard to adherent placenta, while my experience is not great, I have not yet seen a case of entire adherence of the placenta for a number of hours. I have seen several cases of partial adherence where there was a marked hemorrhage and where the hemorrhage was kept up by the incomplete separation of the placenta, with bleeding from the part that had already been pulled loose from the uterine wall. In such cases the only mode of procedure is to pass the hand into the uterus and take out the placenta as quickly as possible. Dr. Hart advises uterine injections following such a procedure. Now, if a man has made his hand aseptic before introducing it into the uterus, there is no necessity afterward for counteracting the effect of his work. The fact that a man feels it necessary to make an injection into the uterus after introducing his hand is a confession on his part that he doubts the efficacy of his precautions. I thoroughly agree with Dr. Hart as to the advisability of keeping the hand upon the empty uterus to prevent hemorrhage subsequent to the expulsion of the placenta. He says at least 15 minutes. I think the rule should be as long as the uterus is at all lax. I am glad that any mention of ergot in the third stage of labor has been omitted, because I think it has no place here. I believe that ergot should not be used as long as the uterus contains anything. I believe that a binder should be applied in every case. Aside from all motives of beauty of form, which influence some women, the binder is advisable because it gives comfort and support. It seems reasonable that after the abdominal wall has been so thoroughly distended, for over nine months, by the enlarging uterus, and when this is suddenly relieved by the expulsion of the child and the placenta, that we should afford some support. I do not think that a pad should ever be placed beneath the binder and over the fundus of the uterus, for I believe that in this way retroversion of the uterus frequently occurs. It is becoming more and more the custom and the expectation on the part of the patient that if the perineum is torn during labor it shall be immediately repaired. I have done this a good many times, and have never found an objection on the part of the patient; on the contrary, she says: "If I am torn, I want it repaired at once." No anesthetic is required, as a rule. There are exceptions, where the woman is unusually nervous. With regard to the repair of the perineum, oftentimes, I think, the obstetrician is inclined to let this go, because he is so tired and worn out. He has been with the case, perhaps, all night, and the child is born early in the morning, and he wants to get to bed. The woman is weary and wants to be let alone. That is no obstacle to the repairing of the perineum, because it has been proven that a man can go home, go to bed, and return to the patient any time within 12 hours and repair the perineum and get perfect results. It does not have to be done at once. I have repaired it as late as 8 hours subsequent to the delivery, with perfect success, and I have read of cases operated on as late as 24 hours subsequent to delivery, without any bad result. Finally, what shall the attending obstetrician do to feel confident that he will not infect his patient? There should be some routine method pursued, and I think the plan advised by the Germans is good. Let every man or woman, in attending a case of confinement, wash the hands to the elbow, for 5 minutes by the watch, with soap and with warm water, and with a nail-brush. Let every obstetrician carry to the confinement a fresh nail-brush for each case. They are cheap; they can be bought for 40 or 50 cents a dozen. Throw each brush away after using. Let them be used for 5 minutes continually. At the expiration of that time, wash the arms and hands again with a solution of bichloride of mercury (1 to 1,000), and let this also be done for 5 minutes. The expenditure of this much time saves a great deal of anxiety to the physician, and oftentimes a great deal of subsequent trouble to the patient. With regard to Dr. Lusson's paper, I wish to say that all elevations of temperature occurring subsequent to labor must not be called puerperal fever. By puerperal fever we mean septicemia. A man lying in bed with a broken leg may contract some contagious disease that causes an elevation of temperature. We do not call that septicemia. A woman lying in bed with a raw and denuded internal surface of the uterus, and with tears in the vagina and perineum, may, and is particularly apt to, contract some contagious disease, as diphtheria, scarlet fever or measles. All these are not puerperal fever.

DR. H. H. HART, of San Francisco: To enlighten Dr. Cheney, in regard to my advice for intrauterine injections in retained placenta, I would say it was simply to wash out the uterine cavity. Sometimes there may be small shreds of placenta remaining, and I think, under the circumstances, that the intrauterine injections would remove them.

Committee on Clinical Medicine, Including Diagnostics and Therapeutics.—The report of this committee [published at p. 253], was read by the chairman, ALBERT ABRAMS, of San Francisco, the title of the paper being "Physiological Pulmonary Atelectasis."

Errors in Diagnosis Due to Vagaries of the Colon.—C. M. FENN, of San Diego, in a paper with this title, said: Functional and organic derangements of the colon often gave rise to symptoms that were attributed to diseases of other organs, even to those outside of the abdominal cavity. The transverse and descending portions of the colon were most frequently affected, the sigmoid flexure being the commonest seat of trouble. This latter was often the seat of an irritation or of an inflammation, amounting sometimes to sigmoiditis. Whether as a cause or as an effect we find associated with sigmoiditis a spasmodic contraction and tendency to constipation, and to accumulation above the flexure. Scybalæ are a frequent concomitant of this condition, and undoubtedly add to the complications. The flatulence may be localized, or may involve the entire colon. If the flatus be confined to the right lumbar division the physician may be called upon to differentiate between phantom tumors, peritonitis, appendicitis, and pregnancy. As an effect of ascent and upward pressure of the transverse arch of the colon, the layman at least may imagine that he is the victim of serious disease of the liver and lung; nor can the physician form an accurate diagnosis without a careful examination of this region. Very frequently neuroses of the left side, including palpitation of the heart and functional disorders of the left kidney and ovary, are due to trouble with the colon itself. The speaker then cited several cases bearing upon this subject, and illustrating the difficulties in diagnosis. These, while mistaken for or ascribed to other sources, had been found to depend upon disease of the colon or derangements of its function, as proved by the relief obtained from appropriate treatment.

DR. M. KROTOSZYNER, of San Francisco: I am sorry that I have not had the opportunity to read Dr. Abrams' paper, as there are so many striking points and ideas I feel I can hardly do justice to it. The fact that such small areas, can, by percussion or auscultation, be found in such an early stage of disease, might in time be of great value for diagnosis of beginning tuberculosis. I fully agree with him that we should never place too much importance upon percussion, as we all know that both sides of the thorax are very often unequal. There may be symptoms of dulness on one side, while really there is no disease present. But if such dulness is found upon auscultation, then we are really justified in saying that there is some disease present. In regard to the second part of the paper, I am afraid the author is a little too enthusiastic in his hopes from "reinforced freezing." He is also, I think, a little too enthusiastic in regard to the diagnostic value of this very heroic procedure. If a physician is not able to diagnose a pleuritis by auscultation, or percussion, or other means, I hardly think that the freezing of the intercostal nerves will aid him a great deal in his diagnostic researches. Being rather remote from the centers of scientific research, we should be grateful to the doctor for his very careful and original investigations. If he is right, that diseases like erysipelas can be favorably influenced by freezing, I think we have in this matter a very valuable therapeutic factor, because with all the therapeutic agents that are known to us at the present time, we still lack a procedure which is not painful, and is at the same time effectual and thorough.

DR. G. F. SHIELS, of San Francisco: I am one of those who, two years ago, took occasion to discuss Dr. Abrams' paper on physiological atelectasis. I think I was a little too ready to ridicule the proposition at that time. It behooves one, when one recognizes the essential merits of the work of a man, when he goes on and perfects it and brings up these composite pictures, which have evidently been the result of successive and careful examination, to recognize the fact that this work is of a sterling character and not of a kind that should be ridiculed. Probably the reason that caused the disposition on the part of one or two of us to speak slightingly of the paper at that time was the term "physiological atelectasis," especially as he used the term atelectasis, which we understand to be pathological, and hyphened it with the word physiological. I think the pictures which he has shown us to-day will be of considerable aid in diagnosis and also in treatment, because he has certainly proved beyond the peradventure of a doubt that there is such a thing as pulmonary anemia, and that by lung exercise the lung may be expanded. I want to go on record as saying that I believe that this continued investigation has proven the original stand he took to a greater or less extent, and I hope he will go on working in this direction. In regard to the second part of the paper, in which he suggests that this method of reinforced freezing might be of value to the surgeon, I think that most surgeons would hesitate to inject underneath the skin, among diseased tissues, a volume of water, and then proceed to further lower the vitality of the parts by freezing them. Of course it is very interesting, and we must accept as a fact what Dr. Abrams has said, and compliment him upon the results. I merely want to put a slight brake on the wheel as regards the application of reinforced freezing in surgical cases.

DR. ALBERT ABRAMS, of San Francisco: I want to correct an impression that is prevalent with reference to reinforced freezing, and that is this: the end always justifies the means. The best proof that reinforced freezing is not so severe as has been claimed by the gentlemen who have spoken, is the fact that I have used it at least fifty times with absolutely no ill effects. I think that justifies the statement that it was a very harmless procedure.

United States Medical Aid Union.—G. F. SHIELS, of San Francisco, introduced the following resolution, which was referred to the Executive Committee: WHEREAS, Any act that tends to lower the proper standing of the medical profession, and to place it on the basis of a trade or business, is to be deprecated; therefore, be it *Resolved*, (1) That the corporation known as the United States Medical Aid Union of San Francisco, and all similar corporations, are, in the opinion of this Society, to be condemned as improper and as tending to lower the standing of the profession by placing it on a level of a trade or business. (2) That any medical man, a member of this Society, who allows himself to be employed by, or otherwise connected with, the United States Medical Aid Association is, in the opinion of this Society, acting in a manner which is unprofessional and which tends to lower him and the whole profession, and which should lead to his name being immediately stricken from the roll of membership of this Society.

AFTERNOON SESSION.

Committee on Medical Topography, Meteorology, Endemics and Epidemics.—W. J. G. DAWSON, of St. Helena, read the report of this committee. He said: Of the five important factors of climate, probably humidity exerts the most influence. Each patient, for whom a change of climate is advised, must be studied individually, and the best locality can only be determined by trial in many cases. Some of the favored sections in our country had undergone climatic changes. This has been ascribed, in a great measure, to cultivation. In California we were particularly favored, as in no place could so many different climates be found. Many portions of our State had long been known as reliable health resorts, yet much less had been written of them than of Southern California. In fact, that section, owing to a lack of silurianism, extensive advertising and the enterprise of the people, backed up in a great measure by the facts, was the only well-known portion of the State. Without in any way desiring to detract from the merits of that section, he wished to speak of a locality that had been systematically neglected by the reports on this subject—Napa and Lake counties. In March, 1876, the speaker had, owing to a consolidation of his right lung, been compelled to seek a more congenial climate than his home in New Brunswick, Canada. After a trial of South Carolina and Colorado, he had settled in St. Helena, Napa county, and had remained there ever since. He had been all over the coast, from Victoria to San Diego, and he had not as yet found a place that surpassed it for climate or for beauty of scenery. The speaker then described the geographical situation of the valley and the topography of the county, with the location of its principal valleys. The climate was less enervating than that of Southern California. The mean annual temperature was lower—that for Napa, taken from a period of sixteen years, was 55.5°, and for Los Angeles, 62.4°. The rainfall was much greater at Napa than in Southern California, yet the relative humidity was much lower than at Los Angeles or San Diego—the figures, as taken from THE MEDICAL TIMES, showing that in December and in January the percentage was greater at Napa. While enjoying the healthful influences of ocean proximity, the harshness of wind and fog were not felt here as on the seaboard. The many conveniences of living, coupled with the easy and rapid means of transportation to San Francisco and Sacramento, offered every advantage to the settler to make a permanent home. All that had been said of Napa was equally true of Lake county, except that the diversity of scenery was much greater and the variety of climate infinite. He believed that this county only needed railway communication to make it the greatest sanitarium of the State. A number of tables, showing the climatic features of this region, were included in the paper. In compiling these tables he had given the absolute range of temperature instead of the mean, as he believed it was more essential in selecting a climate, and it was also more intelligible to the laity. Regarding endemics and epidemics, the only one of any importance since the last meeting was that at Oakland, which he believed was certainly caused by drinking infected milk. In this connection he mentioned a case of typhoid fever occurring in a child, a resident of Napa, that had been visiting at Temescal, in which it was possible to accurately fix the period of incubation, which was 27 days. The prevalence of *la grippe* during the past winter had presented some new features. There had been less of the influenza symptoms, and throat manifestations had been more common. A latent form of pneumonia had also been observed in some cases.

DR. W. F. MCNUTT, of San Francisco: A few years ago the idea seemed to prevail that it was in tubercular diseases, particularly in diseases of the lungs, that people looked for better climates; that they were scarcely ever sent to better climates for other than lung troubles. They were sent to high altitudes, with the idea that this was the best possible place, probably because a large number of persons with lung trouble who went to high altitudes seemed to recover and do well, and it was supposed that there was something—perhaps ozone, or a change in the atmosphere, or a lighter temperature—which was developing and expanding the lungs. I think that we pretty well understand that here, as far as diseases of the lungs are concerned, the atmosphere should be aseptic; we look for an aseptic atmosphere; we look for an atmosphere that is dry, sunny, and free from dust. I do not think that altitude plays much part, though we hear so much, and so much has been written on the altitudes of Colorado and the high districts. It is important to get the atmosphere free from dust, sunny and dry. That is the atmosphere that we want for the treatment of diseased lungs--a therapeutic atmosphere; and whether you find it at the sea level, or below the sea level, or above the sea level, it probably does not matter a great deal. It is an aseptic atmosphere that we are looking for. Warmth has certainly been overestimated. It used to be a warm, high atmosphere. Now it makes very little difference whether the atmosphere is warm or cold. A large number of patients suffering with diseases of the lungs will do better in a cold climate, providing there is plenty of sunlight, dryness, and that the air is aseptic. For that reason we find that many persons with tuberculous trouble and chronic bronchitis, and lung trouble of different kinds, are sent to Minnesota and to the cold districts of Canada. A few years ago a large number were sent to Minnesota, and are yet, in the winter, simply because there the atmosphere is perfectly dry, the ground is completely covered with snow, there is no dust, and it is sunshiny. From the Atlantic coast and British provinces they send people away out to Winnepeg, where you would think they would freeze to death, where the temperature is 40 degrees below zero, and yet it seems to be proved by statistics that there is no place on the American continent where they have so many sunshiny days in the year as they do out on the plains of Winnepeg. Of course there the whole winter long the atmosphere is very dry; the temperature is so low that it is absolutely a dry atmosphere, so you have an atmosphere dried by frost instead of snow. You have sunlight in addition, and you have an aseptic, clean, clear atmosphere, free from dust. That is what I think will stand the test in the treatment of lung trouble, so far as climate is concerned. Of course you would take precautions to keep people warm in a very cold climate. But heat debilitates a very large number of people who are suffering from lung trouble. There is a trouble that probably not many people are sent away for; they don't look for climate as they would in lung trouble, and yet the probabilities are that climate will not do more for the lungs than it will do for intestitial nephritis. There is no doubt that life is prolonged as much and probably more by change of climate, by proper climatic and proper hygienic surroundings in intestitial nephritis. You want air to relieve the work of the kidneys. We want a dry, warm climate, and altitude probably has no effect. I have found, and I think that those who have paid some attention to climate for interstitial nephritis or chronic schirrotic kidney will bear out this remark, that it will do as much good and prolong life as much more than in a climate for tuberculosis. We should aim to get a temperature that is sunshiny, dry, and free from dust; we should aim at an aseptic temperature. As far as epidemics are concerned, the author says we have only had one epidemic, and that was a small epidemic of typhoid fever in Oakland. It is very plain that we have in the United States, at the present time, an epidemic of tuberculosis. It is certainly a contagious disease, and it is certainly epidemic. We make a great deal of talk and fuss and the press is greatly excited if a case of cholera lands in New York, or a case of small-pox appears in the city, or a case of yellow fever in Florida or New Orleans. The profession need not bother itself any more about cholera, and about small-pox and yellow fever. The people are educated on those three contagious diseases, and will take care of themselves. The press is excited about it, and it is soon stamped out. There are about 30,000 deaths to 1,000,000 people, or about 2,000,000 people dying annually in the United States. Fifteen or sixteen or eighteen per cent. of these die of tuberculosis—either tuberculosis of the lungs or tubercular meningitis, tuberculosis of the genital organs or digestive organs, or of the bones. So that we have over 200,000 deaths annually from tuberculosis, a contagious disease! If that is not an epidemic, what would you call an epidemic? I think that this is the epidemic the medical profession ought to look after and ought to educate the people of the United States upon. We take the greatest possible precaution if the cholera breaks out; we know that it spreads in the water, or in the milk, or clothes. Every precaution is taken to stamp out the disease, and yet we do nothing at all for consumption. The consumptive goes about our streets; he spits on the sidewalk; he goes into our hotels; he fills a spittoon full; he goes into our houses, everywhere, on all occasions; there is no restriction whatever; he is not treated as a sick man. I think it would be very proper for this Society to do something for the education of the people in regard to stamping out this contagious disease. Consumption, perhaps, never could be stamped out so thoroughly as cholera, but I have no doubt that 75 per cent. or more of the consumptives in the United States could be relieved in a very few years, just by the same intelligence expended on the etiology of consumption that is expended upon the etiology of small-pox, or cholera or, yellow fever. Why should the quarantining of consumptives meet with so much more opposition than the quarantining of small-pox and cholera patients? It is simply a matter of sentiment. A few days ago a physician in the Philadelphia Medical Society tried to get resolutions passed recommending to the Legislature that cases of consumption in Pennsylvania be quarantined, or simply be registered. Opposition came from the medical men objecting to the registration of these consumptives that were sowing millions of tubercle bacilli over the country. It may be a hardship to register a person —a hardship on that person. Is it not a hardship for that person to give consumption and to propagate the disease to a dozen, or twenty, or fifty, or a hundred families?

Dr. L. C. Lane, of San Francisco: I think something more should be said. I may admit that I believe that tuberculosis is somewhat contagious, but exceedingly little so. It is very far from cholera, far removed from small-pox and these other diseases from which we quarantine. I have been practising medicine for 40 years, and for a number of years treated a great many patients. I have treated many a wife and have never known in one single case the husband who was near her, eating at the table with her, sleeping and occupying the same bed with her, to contract the disease and die. There is one single case where I thought it possible that he might have contracted the disease, but still he did not die; he recovered after coughing for a time. In 1874 I spent six months in London, studying in the hospitals, and I gave some attention to the Brompton Hospital, which, as you know, has been given up to the treatment of consumption. There was a great number of cases under treatment there. I inquired particularly at that time in regard to this matter of contagion, in regard to the nurses. Here were 100 patients, who were coughing; the air was filled with bacilli, or could be filled; they had made the windows double, so that it was impossible for the air to get through from the outside. They informed me that not one single nurse who had been there for years had contracted this disease; nurses who had lived among it, eaten the germs, and, you might say, feasted upon them for twenty or thirty years—some of them gray-headed nurses—and not a single one had contracted this disease. I think this indicates that the disease is not very contagious. That we should teach that it is contagious with these other diseases, I think would create a great deal of alarm and tend to give an immense amount of trouble to the poor and distressed who have this disease; and for one I think that our opinion upon that matter should be very qualified. I was very much pleased with Dr. Dawson's recommendations of Napa valley and Lake county. From a great deal of observation of patients whom I have sent to that locality, and among them myself—not for tuberculosis or consumption, fortunately, but for pneumonia which I had some years ago, and I found great relief—I can speak very highly indeed of it. In regard to temperature, an atmosphere for pulmonary disease should be one of low maximum and high minimum. These should be the essential characteristics of it. It should not be exceedingly sultry or hot, nor should it become very cold.

Dr. J. H. Stallard, of San Francisco: I do not think that any one can dispute the fact that one of the principal methods by which consumption is propagated is by the direct communication of the tubercle bacilli. I have probably had even a longer medical experience than Dr. Lane, and I have seen a considerable number of cases in which not so much that the male has taken it from the female, but more frequently that the female has taken it from the male when the husband has been consumptive. It is not infrequent that the wife, who has been assiduous in her nursing, has taken it. At the same time I agree with Dr. Lane in the objection which seems to me impossible to get over, that it would be extremely unwise for the medical profession at this moment to attempt any public denunciation of consumptives. To classify consumption with small-pox and diphtheria would be, in my opinion, extremely unwise. I do not think it is possible to put that sort of restriction upon consumption as can be put, undoubtedly wisely, upon small-pox, for example. It must not be set down that the question of the mortality and troubles of consumption is altogether a question of contagiousness. The conditions of society determine this question, and I happened to have had a personal experience in my native town, which is a most remarkable one, and shows that general sanitation and so on is capable of producing a higher effect upon the prevalence of consumption than, I believe, even isolation would do. In the year 1840, or soon after that time, when I commenced practice, the mortality in my native town was at the rate, I think, of 430 per 100,000 living. In the following years a very large amount of money was spent in sanitary measures. I think 30 miles of sewers, properly constructed, were put into the town between 1847 and 1860, and the rate of mortality from consumption went down to 222 per 100,000; and since that, enormous improvements have again been made. New outfalls have been constructed, more sewers and sanitary measures have been carried out, and I believe at the present moment the mortality from consumption amounts to 170 per 100,000. Now, I think, this is positive evidence of what we owe to general sanitation; to the general improvement of the condition of the people; to their better housing; to attention to factory air, and the ventilation of factories, and to other general sanitary measures which have raised the character and stamina of the people, so that they are enabled to resist, as I believe most of us can resist, when in good health, the effect of tubercle bacilli. I myself am the son of a man who died of consumption. Two of my immediate brothers and sisters died of consumption, but I believe it is owing to a different treatment in the individual in each case that they owed their death, rather to the conditions brought about by unwise regimen, than to the mere imbibing or taking in of the bacilli. Therefore, I think we should say distinctly it is not wise to make a consumptive the object of a public report. I have at this time in mind a patient in whom I discovered bacilli in the year 1882—the first year it was discovered by Koch—and he has had it continually since. He has had several hemoptyses, but still he is alive and tolerably well to-day, and to put that man under the surveillance of a board of health would be an impossible thing to do, with wisdom.

Selection of Place of Next Meeting.—San Francisco was selected as the place of next meeting. It was generally felt that the Society should soon hold a meeting in Southern California, and the experience of those attending the meeting in Los Angeles impelled them to regard a visit to that section with the pleasantest anticipations. It was, however, understood that the City of Angels would be better prepared to entertain the Society in '96, and San Francisco was therefore selected.

Election of Officers.—The Society then went into the election of officers, with the following result:

President	G. L. SIMMONS.
First Vice-President	P. M. LUSSON.
Second Vice-President	ALBERT ABRAMS.
Secretary	W. WATT KERR.
First Assistant Secretary	CHARLES C. WADSWORTH.
Second Assistant Secretary	H. BERT ELLIS.
Treasurer	J. H. PARKINSON.
Board of Censors	H. E. SANDERSON, WM. FITCH CHENEY, T. B. DEWITT, WASHINGTON DODGE, J. M. WILLIAMSON.
Board of Examiners	A. H. PRATT, R. L. RIGDON, H. H. HART, G. F. HANSEN, W. B. LEWITT, WM. FITCH CHENEY, C. C. WADSWORTH.
Alternates	A. P. WOODWARD, J. H. BARBAT, G. W. DAVIS.

Committee on Gynecology.—The report of this committee (published at p. 262) was read by the chairman, W. H. MAYS, of San Francisco, the subject being, "The Curette; Its Indications and Dangers."

Antiseptic Cataphoresis in the Treatment of Metritis and Endometritis. In the absence of the author, W. A. BRIGGS, of Sacramento, this paper was read by the Secretary. He said antiseptic cataphoresis may be resolved into several elements: Positive antisepsis, cataphoresis, electrolysis, galvano-chemical cauterization and certain undeniable but as yet illy-defined interpolar effects. Antisepsis of the uterine cavity and mucosa is the ideal treatment of metritis and endometritis. Antiseptic cataphoresis establishes and maintains this condition more easily, more positively, and more certainly than any other method with which I am acquainted. Cataphoresis is an osmotic flow set up by the electrical current in its own direction. It is also called electrical osmosis and anodal diffusion. In the passage of the electrode a speculum should be used. For this purpose I have devised two forms of speculum [instruments exhibited], which possess the following points of superiority over the speculums generally employed: They are more easily cleansed, more rapidly manipulated, permit a more perfect adjustment of the blades, and a wider opening of the introitus. The combined syringe [instrument exhibited] and electrode consists of two parts: (1) A hard rubber syringe with a heavy piston-rod provided with a vent to regulate the quantity of electrolyte injected; and (2) an electrode which serves also as the nozzle of the syringe. The abdominal electrode may be of clay, as recommended by Apostoli, or of carbon and gelatine, as advised by Kellogg. The most satisfactory electrolyte is a saturated solution of iodine and sodium iodide in creasote. Pledgets of absorbent cotton saturated with glycerole of starch should also be at hand to neutralize any excess of the electrolyte that may escape into the vagina. As the method under consideration is primarily antiseptic, it should be attended by strict antiseptic precautions throughout the entire course of treatment. Presuming that such precautions have already been enforced, the patient may be placed in either the dorsal or the semiprone position, the dispersing electrode applied to the abdomen, and the speculum introduced. The cervical canal and vagina should be cleansed, and the depth of the uterus ascertained by the sound; the active surface of the electrode should be reduced to the proper length by coating the proximal end with shellac or rubber tissue. The electrode may now be introduced into the uterine cavity and the current turned on. The electrode should sweep the entire mucosa as evenly and thoroughly as possible at each sitting. The sittings may vary from 7 to 15 minutes in length, according to the strength of the current, the susceptibility of the patient and the condition of the uterus. The volume of the current may range between 10 and 150 M. A. The use of the poles is subject to the same rules as in ordinary galvano-chemical cauterization. In subinvolution antiseptic cataphoresis affords results unattainable by any other method. Only galvano-chemical cauterization as advocated by Apostoli approaches it in safety, certainty, and rapidity of action. Hemorrhagic endometritis is also amenable to it, and sometimes even when the curette has failed. It is practically efficient in hyperesthetic endometritis, of which dysmenorrhea is a frequent expression. The more recent the endometritis, and the fewer and simpler the secondary changes, the more rapid the influence of antiseptic cataphoresis. This is true, because antiseptic cataphoresis is *par excellence* a casual treatment—is primarily a process of thorough and powerful disinfection. But the secondary changes, engorgement, infiltration, fungosities, and their symptoms, pain, hemorrhage, discharge, are also relieved; first, by removal of their cause, and secondly, by the stimulant effect of the iodine, and the stimulant and caustic effect of the electrical current itself. The advantages of antiseptic cataphoresis over the purely Apostolic treatment are: (1) Thorough and positive antisepsis of the uterine cavity, and even of the mucosa itself, and its consequent immunity from accidents, though rarely following the usual electrical treatment. (2) The remedial influence of the local applications. (3) In certain cases its slighter caustic effect. Its advantages over curettage are: (1) Greater safety. (2) Greater efficiency, both as a palliative and as a curative measure. (3) Avoidance of ether, of loss of blood, and of confinement to bed. (4) Applicability to numerous cases in which curettage is obviously inappropriate.

DR. A. H. PRATT, of Oakland: I want to emphasize the cautions that Dr. Mays gave us with reference to the dangers of curetting and the possibility of puncture. Three weeks ago I was giving chloroform for a very capable man, a man of experience and ability, who has performed the operation repeatedly, and who is far from being a novice in the procedure. He used a larger curette than I am in the habit of using. It was half an inch in diameter across the bowl. In the preliminary operation, the cervical fibers showed, by the amount of resistance, that they were vigorous and strong, and that degeneration was certainly not marked there. Before he could introduce the curette the natural resiliancy of the circular fibers rendered it necessary for him to repeat the process of dilatation; after which he succeeded in introducing it without difficulty, and proceeded to curette at the fundus. To my amazement the handle of the curette seemed as though it had glided within the uterine or at least within the pelvic cavity. The operator immediately withdrew the curette and suspended the operation. Inflammation supervened and in the course of about five days a laparotomy was done in my presence. A small opening was made, and there was an abundance of pus in the abdominal cavity. It was evacuated and the cavity washed out with warm water. In three or four days the woman died, and on *post-mortem* examination the fact of the puncture of the fundus was demonstrated. I merely speak of this from the fact that Dr. Mays mentioned but very few cases. Evidently the accident is not one of frequent occurrence. This case was in the hands of a competent physician, and I saw no reason for blame to be attached to him for the occurrence of the accident.

DR. J. H. STALLARD, of San Francisco: *Apropos* to the question of puncture of the uterus, I remember that in the hands of a no less distinguished person than Sir James Simpson that accident occurred, and he passed a sound through the fundus of the uterus, distinctly feeling it in the abdominal cavity. In those days laparotomy was not employed, but the patient happily recovered without any serious consequences.

DR. A. J. RUSSELL, of Oakland: A year ago Dr. Pinkerton, of Oakland, had a patient in his care, aged 32, who for two years had presented symptoms of irregular discharge from the uterus. The character of the discharge was bloody, with pus. We applied carbolic acid and the various remedies used in that condition of the uterus, without apparent relief. The patient was chloroformed. I was using an ordinary curette with a perforated handle, which allowed of irrigation of the cavity of the uterus during the operation. I found upon careful examination that the cavity of the uterus gave back to the hand the sense of the gritty resisting sound which we are always glad to find in those positions as indicating a healthy uterus. The lower segment of the uterus seemed to be healthy, but at the fundus of the organ I discovered a spot, right at the dome of the uterus, which seemed to be soft and very easily impressed with the instrument. I cautiously proceeded with the operation, trying to come down to the healthy, gritty tissue, at the top of the uterus. Probably ten minutes had been occupied in curetting, when suddenly, to our amazement and alarm, the instrument disappeared into the cavity of the abdomen. The rubber tube, fortunately, was fastened to the handle of the instrument and provided a favorable means of withdrawing the curette from the cavity. The woman was spared. The question that arose in our minds was, What shall we do? Having carefully sterilized the water by previous boiling, and having assured myself that my instrument was entirely clean, and believing that I had succeeded in removing most of the diseased tissue at the fundus of the uterus, I concluded it would be safe practice to watch and wait. In one hour the woman had a violent chill, which continued for six hours. Then a very satisfactory reaction set in. The next morning her temperature rose to 101° F. There was no particular distention of the abdomen, and as no alarming symptom was present, we continued to watch and wait. In the period of one week we had the satisfaction of finding our patient free from fever, and her general condition improved, since which time her health has been better than it had been for two years before. I mention this case to illustrate the fact that the peritoneal cavity is capable of doing wonderful things if you will be careful not to poison it and keep the dirt out of it. Fortunately, the water which passed through that curette had been sterilized by heat. There was no carbolic acid, nor was there any drug of any kind introduced into the douche. The instrument was clean, and the result of the operation eminently satisfactory. I would like to refer to a case of pelvic peritonitis which was relieved at the end of the fifth week by an abdominal section; wherein the peritoneum was poisoned by absorption of pus from the tube on the left side of the uterus. A lady, in her first confinement, with diseased appendages, gave birth to her child in the fall of 1892. As I remember, Dr. Pratt assisted. There was no source of local infection. She was advised against pregnancy on account of the diseased condition of the appendages on the left side, one year before. Through the confinement there was fever, and she had well marked inflammation on the left side. Her temperature rose to 105° F. Things went on, in spite of all we could do, from bad to worse, when at the end of the fifth week, I made an abdominal section, the appendages were removed, the abdominal cavity cleansed, and from that time the woman continued to improve and rapidly regained her former health, and she is well and hearty to-day.

Diagnosis and Treatment of Urethritis Posterior Chronica.—M. KROTOSZYNER, of San Francisco, read a paper on this subject. He believed there was hardly one that had been as extensively discussed as chronic gonorrhea, and he was justified in stating that there was none occurring in everyday practice in which so many errors were made in diagnosis and treatment. The malady had been constantly studied, partly on account of its effect on the constitution and also from the danger presented through infection of the female genital apparatus. Diagnosis was only possible by a knowledge of the modern methods of examination. If a discharge be present, it is only by careful microscopical investigation that we can avoid errors, which often occur. The question whether a chronic urethritis is still infectious will depend on the discovery of the specific pathogenic organism—the gonococcus of Neisser. A great many difficulties in solving this problem have still to be removed, as it is often difficult to distinguish this organism from others which it closely resembles. It is only by a tiresome course of pure cultivation that the question can be definitely settled, and this requires more time, knowledge and appliances than are possessed by the average practitioner. The importance of an accurate diagnosis could be appreciated by the conscientious physician when consulted by a man desirous of marrying, but in doubt as to whether he would infect his future wife. We now know that many of these cases, in which evidences of discharge have almost disappeared, are still infectious, and there was no one cause so prolific of chronic and incurable disease in the female as these old gonorrheas. The late Schroeder, of Berlin, used to say the young ladies of America hated to marry because they saw their friends lose their health and strength after marriage. In making a diagnosis in cases where there was an absence of discharge, the author referred to the two-glass method. He had found this insufficient, and when abroad he had availed himself of the immense amount of clinical material at the clinic of Posner, of Berlin, to evolve a plan that he believed was satisfactory. This was the three-glass method. The patient used the two glasses, but retained a small quantity of urine in the bladder. By passing the finger into the rectum and making pressure on the prostate gland some secretion could be pressed out, and on voiding the urine this would be found in it. He said he had purposely omitted all reference to urethroscopy, as its employment in the deep urethra was generally accompanied by so much irritation as to more than offset any advantage. Here the button sound gave much more satisfactory results. Using massage of the urethra with this, it was often possible to obtain enough of the discharge for diagnostic purposes. Regarding treatment, he looked upon the nitrate of silver as almost a specific, though he was opposed to using strong solutions. It was always well to remember that we should not do harm in any case.

Dr. J. C. Spencer, of San Francisco: It has been handed down to us as a saying of the great Ricord, that heaven is a place where there is no chronic gonorrhea. I think that most of us have found that cases of chronic urethritis are among the most obstinate that we have to treat, and anything which will simplify or arrive at the proper diagnosis—that is, either the finding or the exclusion of the gonococci—is worthy of our most serious attention. The three-glass method proposed by Dr. Krotoszyner, which was first suggested to him in Berlin, cannot be too highly recommended: the first portion of the urine being caught in one glass, the second portion in a second glass, and by expression of the prostatic secretion and of the contents of the seminal vesicles; the third portion is caught with the residue of the urine, in a third glass. By examining each of these secretions separately, the presence of pus cells may be demonstrated or excluded, and, if present, the examination of these for the possible presence of gonococci will clear up many clouds in diagnosis. Dr. Mays, in his paper on the use of the curette, referred to Dr. Price, I believe, of Philadelphia, who said that there is great danger of over-treatment of cases of uterine trouble, with the curette and otherwise. So in the treatment of chronic urethritis there is great danger of over-treatment and the production of a class of unfortunate citizens, who must be called sexual neurasthenics. Therefore, although it seems almost too much trouble, sometimes, to go through this three-glass method, I think it is due to every patient suffering from chronic urethritis to give him the advantage of every means of determining the diagnosis. I am down on the program to open the discussion on the report of the Committee on Pathology and and Pathological Anatomy. Dr. Barber has presented no report, and I simply want to make a few remarks on a very interesting subject—interesting principally to pathologists, but hereafter I think it will become of great interest to the profession at large. There has been within the last few years, dating back not much farther than 1889, a great deal of attention paid to the presence of certain little cell-like forms in carcinoma. The behavior of carcinoma, more particularly the superficial variety, epithelioma, under some circumstances, suggests very strongly the presence of some infectious process to account for its growth. Darier and Wickham, and a number of others whose names it is not necessary to mention, have described these forms particularly. Some are designated as coccidia, and others as psorosperms, and they are found in allied processes. Darier's disease, or the disease in which Darier found these small growths—the vegetative forms—he called vegetative follicular psorospermosis. These supposed parasites vary in their appearance. In some of the carcinomatous deposits they appear as inclusions in the cell protoplasms, or in the nuclear protoplasm, more properly speaking. In others they appear as separate bodies. It happens to have been my good fortune, within a short time past, to have examined certain specimens, one of which was taken from the liver of a man. I do not remember whether the diagnosis was suspected or made before his death. At any rate, upon autopsy, the liver was found to be carcinomatous, and there were metastatic deposits in some retroperitoneal glands. I understand the case will be reported *in extenso* by Dr.

Arnold, one of the surgeons on board the Monterey. He supposed they were coccidia, but they were psorosperms; that is, free bodies lying in the carcinomatous tissue. I have seen, since then, two cases which were submitted to me for diagnosis, in which the presence of these little bodies, these psorosperms, was clearly manifest. It has been recommended by some to use a certain differential stain. It is handicapped with rather a heavy name, being named after those devising it, Erlich-Biondi-Heidenhain. It is a combination of three analine colors, and these psorosperms stain with one color, and the rest of the tissue with another color. I did not use this stain. I simply used the hematoxylin stain familiar to us all, and these psorosperms were very clearly shown as small, rounded, purple bodies. Some of them had a distinct nucleus like a cell. In others the nucleus seemed to be in a state of karyomitosis, as though the cell were about to split. In others I found groups of these small bodies, four or five clustered together. I have gone into this detail because I wish to elaborate my remarks enough for the general understanding and at the same time call your attention to the fact that progress is being made in trying to either eliminate from or classify carcinoma and some carcinomatous diseases under the head of parasitic diseases. To show you how much attention has been paid to this subject, since 1893 there have been 112 contributions from various workers in this department. A large part of my information is drawn from a collective reference on the subject in a German periodical on pathology, by Dr. Stroebe, of Freiburg.

Nocturnal Epilepsy.—F. W. D'EVELYN, of San Francisco, presented a paper on this subject, which, in the absence of the author, was read by the Secretary. He said the recognition of an epileptic habit was all-important, and failure to recognize it might lead not only to serious clinical errors, but also to grave and unjust decisions from a medico-legal standpoint. That the victim of nocturnal epilepsy was entirely free from every manifestation of the disease during the day, could only be determined by careful observation. It would often be ascertained that several symptoms—as vertigo, faintness, etc.—were really phenomena in the nature of aura, but not followed by the usual spasms. Nocturnal seizures might continue for long periods before making that impress on the face that the diurnal paroxysms soon established. This was probably due to the less intense reaction in the former case. He then reported two cases of the disease in detail and illustrated the treatment pursued in each. These cases, while not presenting any special novelty, indicated the necessity for close investigation in the indefinite and obscure symptoms often complained of by young children.

THIRD DAY.—THURSDAY, APRIL 19—MORNING SESSION.

Committee on State Library.—W. A. BRIGGS, of Sacramento, the chairman of the committee, presented the following report: We find in the Medical Department of the State Library nearly 6,000 volumes, consisting of standard medical works and bound files of representative journals. While the individual volumes themselves are valuable, the library as a whole is well-nigh worthless for the purpose of its creation—that of a reference library of medicine. This is not so much the fault of the Board of Trustees as of the medical profession itself. For the Trustees, recognising the incompleteness of the library, have repeatedly appealed to us for assistance in the selection of those works necessary to bring it up to a high state of efficiency. The Board of Trustees is in full sympathy with the wishes of the State Library Committee, and assures your committee that it will do all in its power to further them. Members of the bar are permitted to take books from the library on requisition of the Superior Judge of the county in which they reside. The law department, therefore, is of direct and immediate benefit to the legal profession of the entire State. It seems to your committee that a similar arrangement might be made for the medical profession, to its great convenience and advantage. Your committee feels strongly that the Medical Library of the State of California should comport with the greatness of the State and the dignity of the medical profession—that the library, in its present condition, is unworthy of both. The necessities of the State itself in official consultation of the latest and best authorities on State and municipal hygiene, and the needs of the medical profession, both require the fullest possible amplification of the medical department of the library.

Our profession is clearly entitled at least to equal consideration with other classes of citizens, not only by reason of the services it voluntarily renders to every community of the State, but also by reason of the extra burdens imposed on it by the State in the pecuniary support of the medical law and the compulsory and gratuitous report of the deaths, births, and infectious diseases. We, therefore, urge that the work initiated by the Society last year be carried to its legitimate conclusion, and to this end we make the following recommendations: (1) That the by-laws of this Society be amended by the establishment of a permanent committee on the Medical Department of the State Library. (2) That the committee consist of five members, whose term shall expire only by resignation, death, or vote of the Society. (3) That it shall be the duty of this committee to submit to the Trustees of the State Library monthly selections of such current medical works, and from time to time, as the funds of the library will warrant, of such of the older medical works as may be necessary to complete the library for reference purposes. That it shall also be the duty of this committee to submit to the State Society an annual report of the work accomplished by the committee, and of the condition of the library. The report was referred to the Executive Committee.

Committee on Medical Education and Medical Legislation.—The report of this committee was read by the chairman, W. S. THORNE, of San Francisco. He said a thoughtful review of the century of American medicine and surgery fills us with admiration for the great men who have adorned this chapter in our history. The names of Rush, Dudley, Mott, McClellan, and Sims, lead us to conclude that America has kept pace with older civilizations in medical progress under conditions apparently unfriendly to scientific training. These men were even original in their methods, and daring and brilliant in their execution. The speaker, having paid a fitting tribute to McDowell, the pioneer of ovariotomy, said: The increasing facilities for intercourse with the old world, and the augmented wealth of our people, have resulted in an exodus of American students to foreign medical schools. The impression had thus gained ground, both at home and abroad, that the medical sciences, if taught at all, are very imperfectly taught in America. Foreign qualifications were very like foreign garments, that are ill-fitting and require to be turned up to suit the length of the wearer. The fashion is un-American and detrimental to the fair name of our schools abroad. If our educational system is defective, it is the sacred duty of the medical profession to perfect it and place it upon an equal basis with the most advanced of the age. Foreign travel is to be commended in our graduates and younger medical men; but they are to learn, and through them the public are to be taught, that American colleges are quite equal for the highest and most perfect work of the medical man. If, under our form of government, the State is remiss in exacting a uniform standard of medical examinations, it is the more imperative that the profession at large favor those institutions and their graduates, that enlarge their curricula and lengthen the period of study. The absurd pretentions of Hahnemann, and the irrational theories of eclecticism, will merge into a brighter and more enlightened philosophy, when medical schools shall adopt the four-year course and a uniform standard of instruction in the fundamental branches of American science. Under this system of education, there need be no misunderstanding as to therapeutics. The speaker then compared, at length, the requirements for graduation, and the course of study pursued, in the German and in the English schools. This, when contrasted with American colleges of the first class, showed that they compared very favorably with the minimum requirements of the English colleges, and still more so with the German institutions. Medical colleges requiring only two full courses of lectures were steadily decreasing in number, and at the present time 96 per cent. of all the schools in the United States had adopted a three-year course of six months each. In this matter great assistance had been derived from the various State Examining Boards. The potency of this factor would be appreciated when it is considered that these boards directly control the recognition of diplomas in an area embracing about forty-one millions of people. For the purpose of obtaining data regarding the respective merits of foreign and American schools, the author addressed a circular letter of inquiry to the heads of several of the more prominent colleges of the country. The replies to this letter were included in the paper. From the data obtained, he was impressed with the fact that medical education in the United States is rapidly approaching in thoroughness, the best European models; and that at the present time the chief distinguishing feature is the requirements in preliminary education. Regarding medical legislation, he said: The laws in this country were defective. The absence of the wise and uniform control by legislation had resulted in innumerable schools of low standard, and in licensed and unlicensed quackery and crime. A diploma should not confer the right to practise medicine. That power should rest only with independent Examining Boards. No foreign degree should authorize its possessor to practise medicine in the United States without examination. Such a course would increase the respect of foreigners for our profession both at home and abroad.

Dr. C. C. Wadsworth, of San Francisco: I do not think that I can say anything to add to the paper just read by Dr. Thorne. I certainly will not attempt to criticize the advancement that is advocated. There is no question but that preliminary education is all essential. It has been too often neglected. I think, also, that four years at least should be required, for no student can avail himself of clinical advantages and acquire clinical experience in less than that time. I agree also with Dr. Thorne, that each State should have its Examiners, either one or two boards, and that an examination should be made of all practitioners, all new-comers at least, both of native and foreign schools. The laws of the State of California are so imperfect that I hardly think it is necessary to go into a discussion of that point, as the subject has been very well ventilated for the last 16 or 17 years. It is almost impossible for the profession to undertake to punish violators of the law here without the cöoperation and assistance of the authorities. It should be the duty of the police to see that all violations are punished, in the same manner as they would any other criminal offense, and when that time is reached I think that the matter can be controlled. When the people wish to have a law enacted or enforced it is usually enforced.

Dr. G. F. Shiels, of San Francisco: Dr. Thorne's paper is of a great deal of interest, and there are some points in it which seem to me to be worthy of a little further discussion. In reference to the exodus of American medical men, both as students and afterwards as graduates, to Europe, it is more or less the direct fault, if I may use the term, of the Americans themselves. Our people are too much in the habit of having a sort of Anglomania—a European mania—and to look up to the European who arrives in this country as having something superior in him. I am not referring particularly to the medical profession, but to the people at large. It is a "fad," an American fad, an un-American American fad, if I may use it, to admire these people. Of course, there is something which aids that a great deal, and that is the fact that the European medical man who comes here to practise begins at once to belittle the American degree. The Germans tell their patients, "We all know that he is an American graduate; he does not know very much. Of course he is a very nice fellow, but he has not had proper opportunities for education." The result is they undermine their profession. It is a practice among the German and French graduates. I have heard them do it; and it is a practice, I am sorry to say, among the graduates of British schools. They deliberately go to work, for their own end, to undermine the standing of the American medical man who has graduated in this country. They even go further. Our country is one where there is not a very large leisure class. There are not many rich fathers who have sons whom they allow to have any length of time to graduate. In America men frequently have to work during their early years to get money enough to make it possible for them to educate themselves as physicians and surgeons, and sometimes it is true that they are not the polished, classical scholars that you find in the older countries; but that is no reason why they should be belittled, and yet it is the custom to belittle them, and the young Americans are frequently made to think, by constantly hearing this, that really the degrees that they take in their own country are not worth having. It is the fault of the Americans themselves, to a large extent, that these young men go abroad to take their degrees, and that after taking their degrees in this country they are afraid to stand on those degrees, and feel that they must supplement it so as to be outside of the possibility of being only American graduates. That is all a mistake. Then, to make things worse, you find medical men who ought to have more dignity and self-respect who, after they have been in practice for years and have gained a standing in the community in which they live, shamelessly leave the town where they have established themselves and go to Great Britain or to Germany and subject themselves to the indignity of an examination for the purpose of getting one of these degrees, and then they come back again and say that they have a European degree, and they publish it in the papers, whereas it is really not a degree at all. A degree is given by a university; it is a scholastic thing. You cannot go and be an assistant to a physician and make that count in Great Britain in a university. One is a university education, and the other is an examination by a board calling themselves a Royal College. These are not degrees, but merely qualifications. One of the reasons why our medical education in the United States is not up to a proper standard in some degrees is this: it lies in the underlying search for the almighty dollar. Men want to make money. They don't want to practise medicine as a profession, but they are trying to make it a trade for the purpose of reaching out indefinitely for money, and the result is that they soon do make it a trade. Even the universities have not yet, in our country, appreciated the fact that medical men should not be looked upon as tradesmen, but should be placed in the teaching chairs which they occupy as high dignitaries, and should be paid ample salaries, so that the necessity of practising medicine as a means of livelihood should be done away with. The men who occupy professional chairs should have time to teach, and they should raise the standard and dignity of the profession. As far as the early education is concerned, there is no question in the world but what the higher you make that the better. The more educated a man is when he commences to study medicine or surgery, the better able is he to cope with its difficulties. Still there is such a thing as making that education unnecessarily extensive. You cannot over-educate a man, but you may use up so much of the better time of his youth that when he arrives at the point of studying medicine he may have used up the best years of his life in literary education and have to put medicine through at a great rate. That is a point I want to call attention to—the fact that we try to stuff into a three or four years' course too much work for the student and neglect proper physical exercise and mixed sport, and often the student comes out anemic and run-down and thoroughly broken up. I think that the answers from the University of Yale are the best answers the doctor had; they are very much to the point. I would like to make a few remarks on medical legislation. The farce of the State Society's efforts at medical legislation is too well known to us all to need to be spoken of here, and I want to voice a sentiment here which I believe to be absolutely correct. When the people of any country feel it necessary to correct an evil which they have discovered and felt, they will do it for themselves. No body of medical men can go out and dictate a principle to the people at large. They feel themselves perfectly capable of taking care of their own interests. When the time arrives that the American people feel that the condition of affairs is as we know it to be, then they will legislate to protect themselves. Medical legislation is a farce. Let the people legislate when they feel it necessary to protect themselves against what we know to exist—gross quackery.

Committee on Indigenous Botany, Materia Medica, Pharmacy, and Medical Chemistry.—W. P. GIBBONS, of Alameda, the chairman of the committee, had taken as his subject "Some of the Poisonous Plants of the Pacific Coast." His definition of a poison is: "Any substance which is taken into the system, or which comes into external contact with it, in small or large quantities, which has a tendency to impair or destroy life." Of course, this will include many genera of plants indigenous or naturalized on the Pacific slopes, whose representatives hold a place in the pharmacopeia, but whose special properties are yet subjects of further investigation. The speaker proceeded to designate them in the line of their natural order, without any special detail of their properties, as their medical history may be found in the reports of his papers during the last ten years, read before the Society and published in its annual proceedings. This catalogue included about 25 species of known or reputed poisonous plants, and was followed by a brief allusion to the cryptogams, including poisonous fungi, or mushrooms. This class was shown to be much neglected as an article of food and a substitute for meat, owing to bad reputation and general ignorance of ability to discriminate between edible and noxious species. While there is no doubt that sickness and death have occurred from eating certain varieties, among the most poisonous of which is the *arnaurita muscarius*, formerly used for poisoning flies, such accidents may be attributed, for the most part, to the unseasonable time of gathering, and the neglect of proper precautions in preparing them for the table, rather than to any permanent toxic secretion of the plant. While this species [a figure of which was here exhibited] is so deadly in Europe and elsewhere, the Russian peasantry eat it, first preparing it with salt and vinegar. After arriving at maturity, mushrooms are liable to be attacked by flies and other insects, which impart poisonous properties to the plant. This was shown in a small bottle containing minute coleopterous insects; and another in which were millions of their larvæ, not distinguishable by the unassisted eye from fine dust, taken from a specimen of polyporus, which was exhibited to the Society. In this connection, numerous beautifully-colored illustrations were exhibited. The speaker concluded by stating that there was no general rule by which edible mushrooms can be distinguished from noxious ones; but in all cases they should be well treated with salt and vinegar before being cooked.

Committee on Surgery and Clinical Surgery.—E. H. WOOLSEY, of Oakland, the chairman of the committee, said he had concluded to make verbal remarks, giving, as far as possible, a synopsis of the paper which was supposed to have been written. He had departed from the beaten path to make experiments looking to the physiological and pathological effects of electricity. Much might be said in regard to the advancement of surgery during the past year, particularly the increasing recognition of the vast utility of antiseptics. I have felt that other members and colleagues on this committee and other members of the Society would do justice to those questions. I have long maintained the idea that electricity did not receive the attention which it deserved at the hands of the profession, and to inform myself upon its usefulness, or its injurious effects, or upon its value, I have set about making a series of experiments, and I shall give you the results of my experience. Since the time of Volta and Galvani many earnest scientific minds have been occupied in working at the subtle effects of the subtle force of electricity, and thereby laying the foundations of rational electrical therapeutics—a rational system. The Electric-Therapeutic Association has made a considerable advancement in that direction, and its members are doing a vast amount of work. During the earlier years of my practice I employed the constant current, as physicians, I think, in general do, using small or portable batteries, and using the ordinary galvanometer as the one test of the strength of the current or as to the effect of current, and the effects upon my patients were probably the same as those usually obtained by the average general practitioner. Sometimes there would be marked benefit; occasionally there would be injurious results, but generally no apparent effect, and I abandoned its use as a reliable agent, and used it then for many years, when I used it all, more as a placebo and more as an hypnotic agent. Some ten years ago, however, upon establishing a private hospital, I commenced using a stationary battery, a gravity battery, and then used the milliampere meter, and by this means was enabled to have a steady, stable, reliable current from day to day, and to measure out the doses of electricity. The experience from that time was very encouraging. I found that I could rely more and more upon beneficial results and have greater and greater certainty in regard to its effects. I did not do as had previously been done. When I came to a case where there was no apparent benefit from electricity, abandoned it in that case, but reviewed my diagnosis and the conditions and sought for error in my methods, because my convictions had already been strengthened to the degree of believing that electricity was particularly useful in certain classes of cases. My convictions to that end had grown, and the classes of cases are gradually increasing, in my opinion, where its adaptability is certain. I found then when using the gravity battery and the milliampere meter that an increasing experience with it enabled me to judge of its effects more certainly and to accomplish much more, just as one is able to do more and more with a powerful drug which he habitually uses. And I would say that the simile is perfect; that electricity is a powerful agent, and, like powerful remedial agents of other classes, it is likewise capable of harm as well as of good. My experience in practice and my experience in experimental observations bears out this idea, and I think that the profession at large, and I am sure that the public at large, do not estimate rightly the dangerous effects of electricity. My growing conviction is that in all cases it is a two-edged sword, and that if it does not cut in the right direction it will cut in a wrong direction, and that, like all powerful agents of the materia medica, it should be used judiciously; and if not so used, if it does not do good it is absolutely certain to do harm. For the purpose of arriving at more exact conclusions, I set about making experiments upon rabbits, and I have been working in that manner since the last of December, at least four hours a day; and but two days, I must say incidentally, during all that period have I failed to work on an average for four hours. I have not had time to make deductions or work out any of the several lines of suggestion from these observations. I have only undertaken to deal with one line in carrying it out to its legitimate conclusion. The other observations are yet so meager that I feel it is necessary, before making further deductions, to repeat experiments and, perhaps, to add new or supplemental lines of observation, which I propose to do. At this session I shall only present to you a tabulation of the statistical observations I have on the question, and charts representing the effect of electricity upon temperature, which is the particular line that I have worked out. Now, a word in regard to my method. I have used electricity conducted by wires to an operating room, from a stationary gravity battery, through a switch, and through the switch connected to a rheostat. I have used Massey's rheostat, which I would most earnestly recommend to all medical men who want to use electricity, because of its reliability and its not being liable to get out of order like other rheostats. It is a graphite rheostat, and whenever it wears out a little bit all you have to do is to rub a lead pencil over the acting part, and you have good connection. To the rheostat is connected a milliampere meter, and in regard to milliampere meters I will say that I have used for many years an old Storer instrument, which has one advantage over the modern instruments, of showing the measure of reversed currents as well as direct currents. But it is not reliable, nor is any other milliampere meter reliable, with the exception of the Weston, which was very fully set forth and demonstrated at the American Electric Therapeutical Association in Chicago last fall; and the Weston was about to be adopted as the reliable instrument, and would have been so adopted but for the promise of the Edison people to furnish one at a less expense. The Weston is somewhat expensive. The small one, which is quite enough for all medical practice, costs $50, and the reading if from 1 to 150 milliamperes, and you can guess a fraction of a milliampere, that was the only objection to any of those instruments, that they did not read fractions low enough. But it is always the same and always reliable, never getting out of order, and you can always count upon its proper action. My conducting wires of flexible material were carried to my rabbits. I had to give a stabile current. It is impracticable to use the labile current, and so I made electrodes of little plates of copper covered with surgeon's lint, which I have found exceedingly useful as a covering for electrodes, and I think it is better than anything else that I have ever used. There has been a great deal of discussion about that in electrical practice for a number of years—about the kind of electrodes. I think any kind of a metallic electrode, especially a copper electrode, covered with surgeon's lint is the most practical form. The electrodes that I used were made of copper, screwed fast to a binding post, and covered with surgeon's lint, and then on top a layer of rubber dam, and over that a strap. The rubber dam serves as an insulator against possible wetting and conduction of the current of electricity to the strap and possibly to other parts of the body, The electrode was strapped to the animal's body or to the head, like a halter for a horse, with the electrode over the forehead, and then the conducting wires attached to the binding posts; and so I had my animal connected. The speaker then exhibited an elaborate chart, giving the results of his observations, in columns. He also showed one of his case-books, in which the records of experiments were kept. The temperatures were always taken in the anus, and always with a Hick's thermometer. He supposed the rabbits kicked about forty dollars' worth of thermometers out. His book represented a summary of observations on 39 adult rabbits treated by electricity during the months of January, February, March and April, 1894. About 50 additional rabbits were used for the purpose of dissection or comparison with rabbits treated, at autopsies. The current is considered weak when not exceeding 20 milliamperes. It would take a great deal of time to discuss the question of weakness or strength of a current, because that all depends upon the resistance of the animal and the resistance of tissues between electrodes, and upon the conductivity of the connecting media and upon the perfection of your conducting wires as a conductor. In regard to rabbits, the current is considered weak when not exceeding 20 milliamperes; medium between 20 and 50, and strong above 50. The voltaic current was used. The current's strength is noted, and its general character, weak, medium or strong, and the number of milliamperes. The speaker then proceeded to give the results of his experiments, illustrating then by reference to the chart already referred to. These comprised investigations as to the effect of electrical currents on the various functions of the body. He concluded by stating that this inquiry was still in progress, and that he hoped to present a further report on some future occasion.

Total Extirpation of the Uterus.—H. KREUTZMANN, of San Francisco, read a paper upon this subject. He said a remarkable tide had set in during the last few years in operative gynecology. A tide drifting away from the ovaries toward the uterus. Conservative treatment had followed the wanton extirpation of the ovaries. This change of tactics, that decidedly meant progress, was brought about by various reasons. The results of removing the uterus and of leaving the slightly diseased ovaries had proved unsatisfactory. On the other hand, total extirpation of the uterus, either vaginal or abdominal, had been rendered a comparatively safe procedure in ordinary cases. The first and most important indication for hysterectomy is malignant disease of the uterus. There should not be a shadow of a doubt that malignant degeneration of the uterus can be safely and permanently cured if total extirpation is done early. He did not rely upon statistics; but when a woman, in whose case a clinical and microscopical diagnosis had been made, could enjoy perfect health for several years, after total extirpation, we must be convinced that a cure was possible. Early operation demanded early diagnosis; and far too often the diagnosis was made too late. Total extirpation had of late years been advocated in uterine fibro-myomata. If the symptoms are severe and the conditions not improved by symptomatic treatment, radical measures were always taken into account. Sometimes the size and situation of the tumor will determine the selection of the particular operative procedure. It was a new operation, and there was need for further experience, yet he had no doubt that it would have a permanent place in operative gynecology. Inflammatory suppurative infectious diseases of the uterine appendages, and of their surroundings, was an indication for hysterectomy. Appendages were sometimes removed and sometimes left, but lately the example had been set by Polk, of New York, and others to remove the uterus in every case of ablation of the appendages, if it was diseased and absolutely incurable. The disputed indication for hysterectomy was prolapse of the uterus. If the patient is near or past the change of life, this operation is undoubtedly justifiable. But if those conditions are not present, more conservative treatment is decidedly called for. Other indications for hysterectomy were then given, and the speaker concluded by discussing the *technique* of the operation. The operator had seen methods advised differing in no essential from others. In vaginal hysterectomy it was immaterial whether the anterior or the posterior vaginal vault was first opened, or whether the fundus was turned through the anterior or posterior opening, or not turned at all. There was a little more earnest difference of opinion as to the use of clamps or ligatures. Personally he had been impressed with the possibility, so desirable in malignant disease, of going further away from the uterus with clamps than would be possible with ligatures. Suprapubic hysterectomy is now done with careful ligation of the ovarian and uterine artery, dissecting the bladder from the uterus under a peritoneal flap, and closing the abdominal cavity. He then, briefly, reviewed the results of his operative work during 1893, comprising eight operations without a fatality.

DR. G. F. SHIELS, of San Francisco: Concerning the indications for total extirpation of the uterus, there can be no particular guide laid down. I think the gynecologist ought to have his mind in such a condition that he can take a moral balance and weigh the possibilities of the patient's life, and whether it is going to make her life miserable and interfere with her well-being, or make her sick, or kill her; it would be his duty to remove it if he could not correct the conditions in any other way. Regarding the point that one should operate in every case of carcinoma, and that you can get a radical cure in all cases of carcinoma, even if you do not operate early, is a point which I do not think is quite so definitely proved as the gynecologist would try to make us believe. Even in cases where we remove the carcinomatous growth early, there is always a possibility of return, and I think the doctor hits the point very well when he says that statistics are not of very much value, and that one must be guided in his opinion largely by his personal experience. One part of Dr. Kreutzmann's paper I want to compliment him on particularly, and that is that he does not stand upon the floor and tell you that to bring down the fundus is the only way, or to bring it down the back is the only way, or to put a ligature on the broad ligament. He is perfectly free to say that any one of those methods is successful, though it is a mere matter of the *technique* of the operator, and I think it is a proper stand to take. There is too great a tendency on the part of specialists to say that the only cut to make is here or there, and that the only thing to do is to pull the fundus down in that way, or by some peculiar technical method that they take hold of to the exclusion of all others. Dr. Kreutzmann has been free in saying that one is just as good as the other. I think that is a point upon which we ought to congratulate him. The indications for the different cuts will be different, and the operator never knows what he will do until he sees the condition, and not until after he removes it will he be able to understand thoroughly what he will do.

AFTERNOON SESSION.

Committee on Histology and Microscopy.—J. R. CURNOW, of San José, the chairman of the committee, read this report. The subject selected was, "The Final Distribution of the Nerves of the Viscera, with some Remarks upon Histology in General." The report was a lengthy but exceedingly interesting one, and showed every evidence of careful preparation and research. The author first took up the subject of histology and enumerated the advances in methods that had been put forward during the year. New methods of staining were mentioned, and their bearing on histological investigation of the nervous system pointed out. The speaker next took up the final distribution of the visceral nerves, the different organs being discussed in detail, and the fact dwelt on that this knowledge was, in a great measure, due to improved methods of preparation of specimens.

Executive Committee.—This committee, through its chairman, J. H. PARKINSON, of Sacramento, made the following report on the various matters that had been referred to it during the sessions: *Report of Treasurer Board of Examiners:* Accounts, vouchers, and bills of Treasurer Board of Examiners audited and found correct. *San Francisco Medico-Chirurgical Society:* Committee recommends that the Medico-Chirurgical Society, of San Francisco, having adopted the Code of Ethics of the American Medical Association, be formally recognized by the State Society. *Legislation against purulent ophthalmia:* The committee recommends that the purpose of the bill presented by the San Francisco Society of Eye, Ear, Nose, and Throat Physicians be endorsed by the Society, and that the bill be referred to the Committee on Medical Legislation. *Communication from California State Veterinary Association:* The committee believes that the objects of this communication relating to the suppression of infectious diseases in animals are good. It recommends that the matter be referred to the Committee on Medical Legislation for such action as it may deem best in the premises. *Secretary's report:* Examined and found correct. *Treasurer's report:* Examined and found correct. *Appropriation for entertainment of American Medical Association:* The committee recommends that the amount named in the resolution ($2,500) be appropriated to be expended by the Committee of Arrangements of the American Medical Association. *Recommendations in President's Address:* (*1*) *Reduction in dues:* The committee believes that it is inexpedient to reduce the dues of the Society, and would point out that in 24 years it has only accumulated a small amount, and that in its past history it has, on several occasions, been in debt. (*2*) *Continuous memmership in the local society:* The committee recognizes that in some rare and isolated cases this rule may work a hardship. It is, on the other hand, productive of a vast amount of good in perfecting and in maintaining our professional organization. It has been the means of excluding from our meetings those heated debates and unseemly wrangles that have obstructed scientific work and wasted valuable time. It is a permanent bar to their recurrence by placing all matters relating to professional conduct within the jurisdiction of the local society. It is the strongest element in the creation and maintenance of county societies. It is therefore strongly recommended that no change be made. (*3*) *Quarterly bulletin:* The committee has carefully considered this question but finds that the time at its disposal, with the absence of the necessary data, will not admit of an intelligent report. It therefore recommends that this matter be referred to the incoming Executive Committee with instructions to report at the next annual meeting. (*4*) *Code of Ethics of the American Medical Association:* The committee is most heartily in accord with the letter and with the spirit of the President's address in relation to the Code and the proposed revision. It earnestly recommends that the Society unanimously indorse the Code of Ethics of the American Medical Association and record itself as unalterably opposed to the suggested changes therein. (*5*) *Criminal abortion:* This matter is not sufficiently definite, the committee therefore recommends that it be referred to the Committee on Medical Legislation for such action as may be deemed proper. (*6*) *Embalmiug:* The committee believes the suggestion that embalming of any body should not be allowed until permission has been granted by a coroner or other proper officer, is good, and recommends that the matter be referred to the Committee on Medical Legislation for action. (*7*) *Publication of names of deceased members:* The committee believes that the intention of this recommendation is now fully covered by the reports of the Committee on Necrology. *United States Medical Aid Union:* The committee approves of this resolution and strongly condemns the methods adopted by the Medical Aid Union. It recommends, as a means of discipline, that upon complaint, in writing, being made, any member of the Society who has acted in violation of the spirit of this resolution must, after proper investigation by the President and Secretary, be suspended from membership until the next regular meeting of the Society. *Committee on State Library:* The committee believes that the recommendations of the special committee are good, and favors the creation of a standing committee on this subject. This being an amendment to the by-laws, according to Article X, Section 1, it cannot be acted upon at this meeting, as it requires one day's notice. It is, therefore, recommended that the present committee be reappointed, instructed to continue its work, and to report at the next annual meeting.

Installation of Officers.—The business of the session having been concluded, DR. C. G. KENYON, the retiring President, expressed his regret at the small attendance at several of the sessions. This was not due to lack of work on the part of the committees, or to want of material, but to a number of causes beyond the control of the Society, all combining to make this an off year. During the past 12 months he had endeavored to discharge the duties of his office in as thorough and conscientious a manner as he was capable. He had, when in the chair, endeavored to be impartial, and he felt justified in saying that every effort had been made to carry out the program, and to have the various papers read on time. On motion, the newly elected officers were declared installed.

New Members.—At the different sessions the following were duly elected members of the Society:

W. O. Anderson.
R. H. Burke.
Elizabeth Gallimore.
M. Gardner.
Geo. F. Hanson.
C. W. Jones.
Oscar J. Mayer.
J. S. Potts.
A. J. Russell.
A. J. Sanderson.
E. H. Smith.
J. W. Thayer.
Godfrey Vivian.
A. H. Voorhies.
W. Winterburg.
H. J. B. Wright.
J. Wright.

The following were reinstated:

C. L. Bard.
A. T. Hudson.
Thomas Kelley.
H. E. Mueller.

The Society then formally adjourned to meet in San Francisco on the third Tuesday in April, 1895.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Annual Meeting, March 20, 1894.

The President, F. L. ATKINSON, M.D., in the Chair.

American Medical Association.—A communication was received from the Sub-Committee on Finance of the Committee of Arrangements of the American Medical Association, requesting a contribution from the Society towards defraying the expenses of entertaining the Association at the meeting to be held in San Francisco next June. The Secretary was ordered to open a subscription list, and an opinion was expressed by several speakers that a liberal contribution should be made.

Annual Address.—DR. F. L. ATKINSON, the retiring President, delivered the annual address, in which he referred to the continued progress of the Society, and to its increasing membership. He drew attention to the fact that an increase in the number of cases reported at the meetings was desirable, and said that every member should prepare and should read a paper in his turn. It was a fact that some of the members most competent to prepare papers, were really the most derelict in this respect.

Election of Officers.—The following were duly elected officers for the ensuing year:

President	W. F. WIARD.
Secretary and Treasurer	W. J. HANNA.
Trustees	G. L. SIMMONS, H. L. NICHOLS, W. A. BRIGGS, W. F. WIARD, W. J. HANNA.

Leprosy.—H. L. NICHOLS said that it had been impossible for him to prepare a paper. Twenty years ago he had read a paper before the Society on Leprosy, which, as far as he knew, was the first publication upon the subject in this State. He was prompted to write the paper from the fact that many people at that time employed Chinese in their families, and it was not uncommon to see a China boy taking care of the children. Many of the Chinese who came here had leprosy. The speaker had been impressed at that time that the disease was contagious, and that the community was in danger from its spread. About one year ago he had been called to see a Mexican woman in this city, and had diagnosed the case as one of incipient leprosy, perhaps amenable to treatment, and not presenting any danger to the community. For this view he was roundly abused in some quarters. The woman subsequently went to San Francisco, and was there seen by several physicians, two of whom he understood had certified that she was not affected with leprosy. The woman had since returned, and the question had now arisen in a new form, as her son, who was 12 years of age, had been refused admission to the public schools. He submitted the question to the Society for discussion, and in conclusion said there were other complaints that were more contagious than leprosy, and yet about which no hue and cry had been raised.

DR. T. W. HUNTINGTON said his attention had been called to the case of the boy mentioned by Dr. Nichols, but he had declined to express any view. The State law would govern this case. It provides that any children from a family affected with a contagious disease can be removed from school. There is a legal aspect to this case, as the parents might procure an injunction, and a damage suit would result. If leprosy is not a contagious disease we should allow the boy to attend school and take the result.

DR. F. B. SUTLIFF had listened to the report of the case of the Mexican woman with much interest. The English physicians have decided that leprosy is not contagious, but that it is infectious. Thirty-six years ago there were only two cases of the disease known to be in the Hawaiian Islands, and they were looked upon as curiosities. The Kanakas spoke of them as "mai pake," or Chinese sickness. From this nucleus the disease has spread until there is scarcely a family in the Islands unaffected. It is now endemic in Hawaii, and it was not there before the Chinese came. Fox says, that wherever leprosy establishes itself there it grows and spreads in some mysterious way.

DR. W. E. BRIGGS: Syphilis and leprosy resemble each other; only the stage of incubation in the latter is longer. During the recent cholera epidemic a reporter went from Paris to Hamburg and was anxious to get cholera. He drank water containing bacilli but did not contract the disease, simply from the fact that the bacilli were not absorbed. It is no evidence that the disease is not contagious because parties have lived together and no bad results have followed. In Norway when there was no segregation the lepers were numerous; but since the government has commenced to segregate them the disease has declined. Every precaution should be taken to prevent the possibility of contagion.

Dr. Thos. Ross: Several years ago a very suspicious case applied for admission to the Yolo County Hospital, and I refused to admit him. The case referred to by Dr. Nichols is, I believe, one of tubercular leprosy.

Dr. G. L. Simmons: I have seen a dozen cases which we believed to be leprosy. The first was that of a remarkably healthy boy born in Sacramento county, and living upon the banks of the Sacramento river. The case was a very bad one and he subsequently died in the hospital. The boy had been shot with rock salt while robbing an orchard, and there was a large ulcerated surface on the buttocks. He had associated with Chinamen and Kanakas who lived on a scow where there was a case of leprosy. They used to bring him food and assist in dressing him, and possibly infected him by contact with the exposed surface.

Dr. G. A. White: I have seen quite a number of cases of leprosy. One case was in the hospital for several months. The fingers were enlarged and distorted, and one of them had been removed by Dr. R. H. Plummer many years ago. In one case, that of a boy who lived near the Lake House, his father had employed a leprous Chinaman with whom the boy associated and with whom he sometimes slept. The primary symptoms of the disease in this case appeared shortly after the boy had been vaccinated, and, while there was no evidence to the effect, the father had always ascribed the disease to that source. The first symptoms were a herpes circinata and some scaly disease of the palms of the hands. The speaker said that the father had informed him that he had been subject to attacks of ringworm, and that the eruptions on the boy were similar to that with which he had been affected.

Dr. W. A. Briggs: My knowledge upon this subject is very limited, having, I think, recognized but two cases. My reading has convinced me that the disease is microbic, that its incubation is long, and that it should take its place amongst those diseases that are called venereal. I think an evidence of this is its spread among the Hawaiians, a people particularly loose in morality. The cases that have been mentioned this evening are cases in point, and are proof that the disease is communicable. The disease is not communicated, as the exanthemata by the air, but by contact. Segregation has prevented its spread, and it assumes a different form. Isolation is the best plan, according to the present state of our knowledge.

Dr. W. F. Wiard: I should dislike to have my children attend school with a boy whose mother had leprosy. I consider these cases a menace to public health, and we should err on the side of safety.

Dr. J. R. Laine: I saw the case mentioned by Dr. Ross. The patient was a sailor, who had deserted his ship abroad, and when traveling about had meretricious intercourse with the natives. He was furnished with clothing and some means, and subsequently went to San Francisco. I have before now expressed the opinion that the formidable view of this disease is taken from the scripture. Moses took an account of the disease. He was a sanitarian, and caused 40,000 persons to be put to death on account of practices detrimental to the health of the people. He gave laws which might have been intended for syphilis. Two years ago the question of a State lazaretto was proposed, but it was finally determined that it was not an acute contagious or infectious disease; and if a lazaretto were established it would be simply a rendezvous for all the lepers in the United States. Leprosy is upon the decline. There are only 11 cases in San Francisco and 2 in Sacramento county. Two hundred years ago there were 6,000 cases reported in Europe, but the statistics were so loose that they all may not have been lepers. We do not care to stamp out syphilis, and do not take much notice of diphtheria. The well-living of our people tends to keep us free from leprosy and its dangers.

Dr. J. H. Parkinson: I have seen cases in India, China and Japan, but my practical acquaintance with the disease is due to investigating cases in this county. I have endeavored to trace the history and have had the facts in relations to the cause in quite a number of cases. Reports of commissions in India should not be unreservedly accepted, and some account should be taken as to their reliability and as to the influence that commercial interests exercise in their conclusions. Voluntary segregation has long been carried out in India, and this, in part, accounts for its slow spread. The cases we collected were from healthy parents, but all had associated with Kanakas and Chinamen. In the case of one of these lepers, the daughter subsequently became a leper, and it was afterward ascertained that the father had maintained incestuous relations with her. There is no cure for leprosy, and the dread is, therefore, caused from its certain fatality. The best way to prevent its spread is by isolation and segregation. The Mexican boy should not be sent to school as long as he is living with his mother. I would not care to have my boy sit in class with him, and I think we would not be justified in taking any chance.

DR. D'ARCY POWER: I have had only one case, an English sailor who had been in China and Japan and had illicit intercourse with the natives. We should isolate every case. In the case of the boy, I should doubt if it would be contagious.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, March 13, 1894.

The President, W. WATT KERR, M.D., in the chair.

New Member.—ARTHUR H. MAYS, M.D., was duly elected a member of the Society.

American Mutual Aid Association.—The Committee on Medical Ethics presented the following report on the American Mutual Aid Association, the constitution of which, and the participation of members of the Society in the same, had provoked a very animated discussion at a previous meeting of the Society. "Your committee, to which was referred the matter of the American Mutual Aid Association, believes the organization of any institution that offers medical services to a person or persons, having a fixed or other income, at a nominal price, whereby the service of the physician will be depreciated and the practice of the general profession injured, should be considered unprofessional. Upon careful investigation, it appears that the consulting staff, whose names appear upon the prospectus of the above-named institution, were under the impression that their names were to be used only as consultants to the Waldeck Hospital, and were unaware of the existence of the Association already named. They cannot, therefore, be censured for this publication, and they have in no manner violated the law of ethics. It further appears that Dr. C. E. Cooper, the prime-mover and organizer of the Association, on learning of the unqualified disapproval of the Society, immediately took steps toward abandoning the project. The committee therefore finds there is no further cause for action."

The Development and Future of Endoscopy of the Urethra and Bladder. M. KROTOSZYNER read a paper on this subject. Having briefly reviewed the history of this procedure and discussed the various instruments in use, he recommended as most suitable for practical purposes the glass endoscopes designed by Posner, of Berlin. These instruments, on account of their dull edges, can be moved backward and forward in the urethra. Owing to the reflection from the tube, the light thrown upon the mucous membrane is so intense that a good view can be obtained even by gas or kerosene illumination. The speaker next described the various pathological conditions that can be diagnosed by its assistance. Post-urethral endoscopy, in his opinion, did not offer very satisfactory results in either diagnosis or treatment, and should be but rarely employed, owing to the irritation caused thereby. Endoscopy of the urethra, while not of such importance as some authors would have us believe, must still be considered an aid to the diagnosis of diseases in this region. The speaker then took up endoscopy of the bladder, or cystoscopy, and dwelt on the difficulties encountered by Max Nitze, of Berlin, the inventor of the cystoscope, in constructing the convenient instruments now in use. He described the requirements that are necessary for a successful cystoscope, and explained the construction of the so-called irrigation cystoscope, by means of which, in cases where, by reason of pus or blood, the bladder is unfitted for cystoscopic examination, good pictures can be obtained. The use of the operative cystoscope was not recommended, as its inventor himself admitted it to be imperfect. Catheterization of the ureter should be attempted only by very experienced cystoscopists. A brief summary of the more important vesical diseases that can be diagnosed by cystoscopy was given, and it was pointed out that previous to the introduction of this instrument many of these were matters of conjecture, whereas now they could be positively verified. Particular attention was directed to the great aid to diagnosis of renal diseases afforded by cystoscopy and the prospects of its more extended usefulness in this direction was mentioned. In conclusion, the speaker said that he regarded the cystoscope as destined to accomplish for the pathology of the urinary organs that which the ophthalmoscope had accomplished for the eye.

Dr. L. Bazet said the endoscope was sometimes, though not often, a means to diagnosis. He regretted that the author had not given the *technique* of catheterization of the ureter, He had the necessary instruments, but so far, except in one case, he had not succeeded. It was certainly a difficult operation, even for specialists.

Dr. J. Rosenstirn said he was not equipped with the modern instruments. With the one he employed he had been able in one case to identify the passage of blood from one ureter; the patient was a female. The newer models ought to overcome many of our difficulties in these matters. We should certainly not underrate the importance of these instruments.

Dr. Dudley Tait agreed with the author that a great degree of perfection had lately been attained in the diagnosis of diseases of the kidneys. There are three difficulties in the use of the endoscope: (1) Obstruction in the urethra preventing the introduction of the instrument, or rendering it very difficult. (2) The amount of heat generated in the instrument. (3) The great experience necessary for its successful use. The speaker then referred to a case presented to the Academy of Medicine [*vide* Medical Times, vol. viii, p. 615], in which he had succeeded in collecting pus discharged from one ureter.

American Medical Association.—Dr. H. Gibbons, Jr., on behalf of the Commitee of Arrangements of the American Medical Association, mentioned some of the methods of entertainment that had been proposed for the visitors. After some discussion, it was resolved to appropriate the sum of $1,500 as the Society's contribution.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, March 5, 1894.

C. N. Ellinwood, M.D., in the Chair.

New Members.—E. Calderon, M.D., W. H. Griswold, M.D., W. B. Coffey, M.D., and Kasper Pischl, M.D., were duly elected members of the Society.

Dr. F. B. Carpenter read a paper entitled "Chronic Bright's Disease of the Kidneys with Special Reference to the Administration of Anesthetics."

Dr. C. N. Ellinwood said that from his experience he thought the danger of anesthetics in patients presenting atheroma was overestimated. Only recently he had operated on a case in which that condition was particularly marked.

Dr. W. F. Southard also thought the dangers of anesthesia in nephritis overestimated. In one year in hospital work he had given anesthetics 700 times, without even approach to an accident. These patients were from all classes, some of them the subjects of nephritis. The ordinary tests for Bright's disease do not certainly indicate its presence. There are changes in the retina, however, which are characteristic. These changes are not always present, but he had never found them in any case in which nephritis was not present. It is wise to have the fundus examined where Bright's disease is suspected. The retinal changes are found before albumin occurs in large quantities in the urine.

Dr. Carpenter said it is probable that accidents from anesthetics in cases of kidney trouble will be less frequent in the future because of better methods of administration, which give greater effect from smaller quantities. He would not argue that such accidents are frequent, but he would insist that many do occur which can be avoided, and that we should be on our guard to prevent them.

Dr. Emmet Rixford presented a case of disease of the skin, which in microscopical sections is seen to be accompanied by large numbers of spherical protozoa, and is probably caused by them. Clinically, the disease is distinct from psorospermosis described by Darier, though quite as rebellious to treatment. The organisms are far more clearly to be made out than are those in Darier's disease, judging from the published descriptions. Their life history from the free spore, through the non-capsulated and the capsulated forms to the adult, which appears as a transparent capsule filled with the spherical spores, is easily followed. Many individual mature forms are seen in which the capsule has ruptured and the spores are being extended. The organisms are often seen in the interiors of giant cells, which are indistinguishable from those of tuberculosis. The lesion is quite superficial, being limited to the skin. It consists of slightly elevated patches made up of hypertrophied papillæ, and is covered in places by a crust due to drying of a purulent exudation. This pus contains numbers of the organisms and many empty capsules. The disease is of two years' duration, and has been generally progressing, till at present it involves most of the back of the neck and the upper part of the face. The disease spreads by peripheral extension, as well as by the formation of new foci of infection. The lesions do not cicatrize, but in the older parts a fairly smooth raw surface is left which exudes considerable quantities of pus. The disease is readily produced in the dog by bringing pus from the lesions in contact with a scarified surface. In the dog there is also evidence of multiplication of the organisms. Dr. Rixford exhibited stained sections showing the protozoa, and the chief characteristics of the lesion.

SPECIAL CORRESPONDENCE.

ROME.

The Eleventh International Medical Congress.—Opening of the Congress by the King and Queen of Italy.—The Meetings of the Sections.—The Surgical Section.—Notable Papers.—The Average Standard of the Communications.—The Difficulties of Obtaining an Official Report.—Hungry Doctors.—Bad Management in the Distribution of Invitations to the Receptions.

The Eleventh International Medical Congress has now been in session three days and has established itself as the most successful ever held. Over seven thousand medical men have registered. The vast Policlinico is none too large for the uses of the Congress. Nineteen general sections, thirty national committees, numerous special demonstrations, are all well accommodated in separate chambers. And more than these, we find a postoffice (under government control, of course), a letter delivery office, several large public writing rooms, a restaurant and the rooms of the administrative officers. Guido Bacelli, the President of the Congress, is a consulting physician of Rome, a professor in the Roman University, the Director of the Medica Clinica, and Minister of Public Instruction in the present cabinet of King Humbert of Italy. Through attendance on former Congresses he knows personally the greater medical minds of Europe. His position in Italy is preëminent, and to his judgment and the weight of his position much of the success of the Congress is due. It emphasizes again the fact that in the selection of a head to such an undertaking, a man who has outgrown the confines of his own town, his province, and his own country, should alone be selected.

The Congress was officially opened on March 28th by a vast concourse, and in the presence of the King and Queen of Italy. Crispi, the Prime Minister, welcomed the delegates to Italy; Ruspoli, Prince and Syndic (Mayor) of Rome, welcomed the members to the Eternal City; Virchow, as President of the Tenth Congress, spoke, in Italian, of the pleasure and profit his nation had derived from the last Congress; and then Bacelli, as President of this, the Eleventh Congress, declared it officially opened. Then followed representatives of the different nations represented at the Congress—thirty-five in all—and each one speaking in his own language. The whole ceremony was in royal style. The King and Queen drove in coaches of state to the opera house; soldiers, with swords at present, kept the passage clear for their majesties. The King and Queen were seated on a raised dais, with royal canopy overhead, and about them were members of the high court, Embassadors of the different countries, and high military officials. All wore court uniforms. The King stood throughout the entire ceremony, with the Queen seated by his side.

Next day at the Policlinico the actual labors of the Congress commenced. By 9 A. M. every section was in working order, and then it became apparent how necessary a command of languages is to one who would profit to the utmost by such meetings. For instance, in the Section on Internal Medicine Warfringe, of Sweden, read a paper on the Treatment of Progressive Pernicious Anemia; Rummo, of France, responded, and Cerdorelli, of Italy, each in his own tongue. Then Monyaras, of St. Louis Potosi, Mexico, read a paper. It is amusing at times to see the President of the section puzzle over some question asked him by a foreign delegate. Fortunately, in the audience there are always volunteers ready to translate. The delegates rarely remain in one section any length of time. Each morning, and during the day, the Official Guide is distributed, with the latest news of interest to delegates. It contains a list of papers to be read in each section for that day—the titles of papers printed in the language in which they will be read. French, German, English and Italian are the official languages. Oftimes a paper is passed when the reader does not appear in his order. In the Surgical Section ten names have been called without a response. But as more than 3,000 papers have been handed in, there is abundant material for the session. One day of the Obstetrical Section was devoted to a discussion of Symphyseotomy *vs.* Cæsarian Section. Representatives of Italy, France, Belgium, Bulgaria, Germany and England were heard. Martin, of Berlin; Championière, of Paris; Moristani, of Naples, and Leopold, of Dresden, also took part. Péan, of Paris, whose name is well known in French surgery, presided over the Obstetrical Section on Friday. He also read a paper in this section on "Miomoectomia Vaginale."

In the Surgical Section, the paper read by Dr. Murphy, of Chicago, on "Cholecystoenterostomy, with a report of twenty successful cases treated by means of the Murphy button," created considerable interest. The English surgeons were stolidly indifferent; the French surgeons, who, as a rule, are little educated outside their own language, could not understand; the Italians were curious, and the Germans regarded the paper as sensational. Rosenberger, of Wurzburg University, reminded the author of one case where the button had not passed the intestine after necrosis took place. Sonnenborg believed it was a dangerous procedure to leave the button *in situ*. Senn, of Chicago, is very much opposed to the method. Murphy is a good speaker, and in the limited time (5 minutes) allowed to each speaker made quite an impression.

The latest statistics place the number of Americans in attendance on the Congress at 200. Until yesterday no organization was effected, and if tickets were to be allotted for concerts or lunches, etc., many of the members were omitted. To better obtain recognition, the members met and elected officers, as follows: Dr. Jacobi, of New York, President; Dr. Tobin, of Canada, Secretary; these, with Dr. Manley, of New York, and Dr. Simmons, of California, to form an executive committee. The administration were so notified, and the same day tickets for the municipal concert, given by the City of Rome to the delegates at the Constanzi Theater, and for the reception at the palace of King Humbert, were sent in. So much for being organized.

Among the more interesting papers read thus far are: "The Management of Typhoid Fever," by Burney Leo, London; "Il Parassitismo nel Cancro," by Foa, Turin; "The Treatment of Certain Neuroses by Cerebrine," by Althaus, London; "The Treatment of Peritonitis," by Lawson Tait, of Birmingham; "Étude Clinique Sur 64 cas de Treparration du Crane," by Championnière, Paris. In this latter paper the author claims good results in certain forms of meningitis accompanied by pain, vertigo, etc. The jacksonian form of epilepsy alone does not give good results. McEwen, of Glasgow, spoke on a new method of reaching the mastoid antrum through the supramental triangle, from which the whole tegmen antri and tegmen tympani may be exposed. The papers presented to this Congress were indiscriminate. Everything went into the grist mill; quality of material did not make much difference. Papers that had been published more than a year ago were admitted. A representative of one of America's foremost scientific institutions had withheld a paper, feeling, as he did, that it might not be worthy of an International Congress, and then to find that Dr. X sends in a rehash paper on "Typhoid Fever," or the "Action of Bacteria in Milk," on which subjects barrels of communications have already been written.

In the meeting of our delegates, a very serious member from Canada stated that he had been personally delegated to represent his government and to bring back a full report of the proceedings of the Eleventh International Congress. He had sent in a paper some months previously. On reaching Rome, and after a week's "botheration," he finds neither his paper nor himself mentioned, nor any trace of the paper which he had registered at the postoffice. But what he most wanted was information, and he was willing to pay for it. He wanted a report for his government, and he found no English-speaking person who could give him the information. Our committee helped him to the extent of an audience with the Secretary-General of the Congress. This, he declared, was a more difficult matter than an interview with the Pope, whom he had visited a few days previously.

The sections generally adjourned for lunch at 12 M, The Policlinico being some distance from the city itself, a restaurant had been provided in the main building; but no provision had been made for a sufficient number of waiters—and the scramble for food! By the second day of the session the management found it impossible to have a full dinner served. Thousands of hungry doctors wanted food at once, and were making their wants known, too. The waiters increased the delay by holding back until "tipped," and even then they had more than they could attend to. It became a question as to whose "tip" was of most importance to the waiter. I have myself sat for an hour with the results of a cup of consomme at the expense of 30 cents, American money.

It has been noticeable, in the American Section at least, that the official distribution of tickets was very unjust. At the King's garden party, to which 4,000 invitations were issued, not more than twenty Americans were invited; and yet hotel porters were selling tickets for the same at 5 lires.

A little incident that occurred lately may explain. Dr. Stewart, our active Secretary, was sitting in the headquarters of the American delegation, when a messenger from the Secretary-General's office brought in an envelope. He was making an exit with the envelope when Dr. Stewart stopped him. Even then with difficulty did he obtain the package. It proved to be a bunch of tickets for the concert in the Corestanzi Theater, given by the municipality of Rome to the Congress. Had Dr. Stewart delayed, the tickets would no doubt have found their way to the hotels, at a fixed price, of course.

G. C. SIMMONS, M. D.

ROME, April 1, 1894.

CORRESPONDENCE.

Proposed Revision of the Constitution and By-Laws of the American Medical Association.

Dear Sir: I might with propriety, perhaps, refer you directly to my letter on the above subject published in the *Journal of the American Medical Association*, February 3, 1894, for my views concerning the revised constitution, as proposed at the last annual meeting by the majority of the Committee on Revision. In that letter it was stated that a careful comparison of the revised document, as presented at the meeting, with the constitution and by-laws as they now exist, showed but four proposed alterations of sufficient importance to require notice. These four are: (1) The very faulty, ambiguous, and even contradictory style in which the revised instrument is written. (2) The omission of all provision for general addresses except the one from the President. (3) The abolition of the Nominating Committee, and the transfer of all its duties to the General Business Committee. (4) The total abolition of the representative character of the Association and of all permanent memberships, and the limiting of the annual membership solely to the membership of the several State and Territorial medical societies. In the letter referred to, the ambiguities and contradictions of style were pointed out in detail, and I will not trespass on your time and space in repeating them here. It is sufficient to say that they are of such a character as to justify the prompt rejection of the whole instrument. The second proposed change, to consist in the omission of all addresses in the general meetings of the Association except the annual address of the President, is in direct opposition to the best interests of the Association, as demonstrated by the experience of all large medical society organizations. No part of the doings in the general meetings of the American Medical Association, the British Medical Association, or of the triennial International Medical Congress, has been listened to with greater interest and profit than the general addresses on medicine, surgery, and State medicine. To omit them would be a serious detriment to the future interests of the Association. The third important change proposed in the report of the majority of the Committee on Revision, as presented at the meeting in Milwaukee, is to abolish the Nominating Committee, and devolve the duty of nominating all officers and places for holding the annual meetings upon the General Business Committee, which is to consist exclusively of *ex-chairmen* of the several sections, and consequently is in no sense representative of either the several States or of the profession as a whole.

Since my letter in the *Journal*, of February 3, 1894, I have learned that the Committee on Revision, at a meeting in Chicago, adopted four amendments to the revised constitution as reported at the annual meeting in Milwaukee, which have never been published. One of those amendments proposes to associate with the General Business Committee, while nominating officers, "One person *appointed* by each of the *State medical societies,*" and from the Medical Corps of the Army, Navy, and Marine Hospital Service. While this is a plain confession that a committee for the nomination of the officers of a great national organization should be a *representative* one, the method proposed is impracticable of execution. In the first place, the General Business Committee is to be constituted of three ex-chairmen of each section, making a total of 33 members, and the addition of one from each State and Territorial society, would increase the number to 75 or 80. As the State medical societies meet at different seasons of the year, one-half of them would forget to appoint a committeeman, and a large proportion of those appointed by the other half would not find it convenient to attend the next meeting of the Association, and it would be impracticable to get a majority of the committee together for the transaction of business. Indeed, at the late annual meeting in Milwaukee it required no little effort to get a majority of the members of the Business Committee alone together for necessary business purposes. But if the proposed scheme could be executed, what could be more ludicrous than to see a great national medical organization assembled in annual meeting dependent for the nomination of its officers on a committee presumed to have been elected or appointed by 40 or 50 subordinate organizations at some time during the preceding year.

Concerning the fourth important change proposed by the Committee on Revision, I cannot do better than to repeat the concluding part of my letter of February 3, 1894, as follows: "Objectionable, however, as are the three foregoing proposed changes in the constitution and by-laws, they are far less important than the fourth, which is embraced in the section relating to membership. For whatever may be the faults and inconsistencies of language used in its construction, as I have already pointed out, there is no difficulty in seeing clearly that its adoption would at once destroy the representative character of the Association, and rapidly reduce its national character by placing the control of each annual meeting directly in the hands of the profession of the State in which the meeting is held. It makes no provision for delegates representing State, county, or district medical societies, and no provision for permanent membership. A careful study of the whole section will show that four conditions are made essential for the acquisition of membership in the Association: (1) The applicant must be a member of some one of the 'several affiliated State medical societies recognized thereby or represented therein.' (2) The State Society, to be recognized, must have accepted the Code of Ethics of the Association. [This is modified by one of the further amendments adopted by the committee at its meeting in Chicago.] (3) The applicant must present to the Treasurer of the Association a certificate that he is a member of a recognized State Society in good standing, accompanied by five dollars as the annual membership fee. (4) If he desires to attend or participate in the work of any meeting of the Association, he must present to the Committee of Arrangements, both a certificate of his good standing in his recognized State Society and his receipt from the Treasurer of the Association that his dues for the year are paid. And if he fails to comply with the foregoing conditions for one year his name must be stricken from the roll of members. The section also declares that 'no person shall be permitted to take part in any annual meeting until he or she has completed the conditions of membership at that meeting, and can exhibit a certificate to this effect from the Committee of Arrangements.' No thoughtful reader can fail to see that the adoption of the section under consideration, as proposed by the Committee on Revision, would utterly destroy the general *representative* character of the Association, and would rapidly reduce the permanency of its membership. The several State and local medical societies no longer appointing delegates with any special or important functions, the attendance from parts most distant from the place of meeting would be less; the interest of the State and local societies in the Association would grow less from year to year, and each annual meeting would be completely under the control of the members living within one hundred miles of the place of meeting, one-half of whom would allow their membership to expire the very next year for non-payment of dues. By thus abolishing the representative character and permanency of membership on the one hand, and on the other, the placing of all nominations and business questions in the hands of a Business Committee composed exclusively of ex-chairmen of sections, it would not take five years to convert the American Medical Association into as perfect an aggregation of specialists, and with as limited a basis of membership, as is the so-called Congress of American Physicians and Surgeons. While the report of the majority of the Committee on Revision makes considerable pretension of placing the Asssociation more 'in touch' with other medical organizations, and of even taking in 'all of North America,' every important change would actually produce directly the opposite effect. On the other hand, our present constitution, the gradual outgrowth of past experience, by its liberal provision for delegates from State and local medical societies, most effectually encourages the formation and support of such societies in every part of our country; and by limiting the privilege of voting to such delegates, it equally establishes and maintains its own true national representative character, and guards against centralization and local or sectional dominance. By awarding to such delegates the privilege of remaining permanent members and participating in all the doings of the Association except voting, by continuing to pay the annual membership fee; and by the section on the admission of permanent members by application without the expense of attending an annual meeting, the door is kept wide open for every member in good standing in the recognized State and local medical societies to make himself or herself a member of the National Association whenever they may choose to do so. Consequently, the present constitution and by-laws are more liberal and more in harmony with every legitimate interest of the medical profession in the United States, and their representative or delegate feature is far more in accord with the modes of thought and action of all English-speaking people than is the substitute proposed by the majority of the Committee on Revision. I am reliably informed that the minority of the Committee on Revision has prepared a careful and well written revision, which retains all the valuable features of the present constitution and by-laws, with a valuable improvement in the General Business Committee, which will be presented in due time, and may be worthy of adoption. But why continue to waste valuable time every year in endeavoring to change the constitution and by-laws? Neither the legitimate interests of the Association nor the value of its *Journal*, will ever be advanced by mere constitution and by-law changes. Such interests can be advanced only by such earnest, thoughtful, persistent work as will bring to every annual meeting better general addresses; more original papers and discussions in every section; and, to the *Journal*, more and better material for its pages. More patient scientific research, more complete aggregation of facts and true deductive reasoning, and more care in the preparation of papers, with less desultory talk or office hunting, should be the motto of every member and friend of the American Medical Association, not only at the coming meeting in San Francisco, but also at all the meetings of the future." Yours truly,

CHICAGO, April 2, 1894. N. S. DAVIS.

REVIEWS AND NOTICES.

AN AMERICAN TEXT-BOOK OF GYNECOLOGY, MEDICAL AND SURGICAL, FOR PRACTITIONERS AND STUDENTS. By Henry T. Byford, M.D.; J. M. Baldy, M.D.; Edwin Cragin, M.D.; J. H. Ethridge, M.D.; William Goodell, M.D.; Howard A. Kelly, M.D.; Florian Krug, M.D.; E. E. Montgomery, M.D.; William Pryor, M.D.; George M. Tuttle, M.D. Edited by J. M. Baldy, M.D. Philadelphia: W. B. Saunders, 8vo, with 360 illustrations in text, and 37 colored and half-tone plates. Cloth, $6; sheep, $7; half-Russia, $8.

Very wisely omitting the usual chapters on the anatomy and physiology of the female generative organs, the authors of this work proceed at once to the consideration of the means and methods of examination. While little new is presented here, the lucid text and copious illustration unite in affording a clearness of exposition that will certainly be appreciated by the student and junior practitioner. The positive insistance on asepsis and antisepsis in the succeeding chapter is a tacit but deserved tribute to the surgeon who made modern operative gynecology possible. In the consideration of endometritis and of menstruation and its anomalies, electricity is by no means accorded the prominence to which its advocates, the reviewer among the number, believe it entitled. Rational and conservative views as to the repair of the cervix are illustrated by numerous drawings. Emmet's operation, slightly modified, is preferred in restoring the perineum. Pessaries and Alexander's operation are accorded a limited field of usefulness; hysterorrhaphy is preferred when the retroverted uterus is firmly adherent. Shuecking's operation and intrapelvic shortening of the round ligaments are condemned. Relief of associated conditions of the pelvic organs and prolonged support with tampons properly constructed and applied, are often sufficient in the treatment of retroversion. The treatment of uterine fibroids is summarized as follows: Small submucous fibroids which can be readily removed *per vaginam* should be submitted to this method. All others demand different procedures. Those cases in which the decision is against operation should be treated by ergot. In all cases of operation, total extirpation is indicated to the exclusion of every other method, unless there be some special contraindication, A valuable and interesting chapter is the concluding one on the after-treatment of gynecological operations. The statement occurring on page 432—temperature after extirpation is unusual—should be eliminated from future editions. Such license in the use of language is wholly inexcusable. As a whole, this work may be pronounced an admirable exposition of modern gynecology, with a bias toward its surgical aspect.

HISTORY OF THE LIFE OF D. HAYES AGNEW, M.D., L L. D. By J. Howe Adams, M.D. With 14 full-page portraits and other illustrations. Philadelphia: The F. A. Davis Company. In one large royal octavo volume, 376 pages, extra cloth, $2.50 net; half-morocco, gilt top, $3.50 net.

As a specimen of book-making, this work is a worthy one. In every respect its *technique* is all that the most critical could exact. Moreover, its literary merit is of the highest order. The author evidences a knowledge and command of the English language, or, better than that, of Anglo-Saxon, absence of which in this age of over-production and reckless compilation is too frequently noticeable. The volume is something more than a tribute. It constitutes a lasting monument to the memory of a man who was conspicuous for his genius and greatness. Had it happened that D. Hayes Agnew had chosen another field of labor, the same power of application, spirit of self-sacrifice, devotion to duty, and stern adherence to the principles of truth in the abstract which placed him upon an eminence as a surgeon and attracted to him the gaze of an admiring throng of followers, would have insured for him similar recognition in the pulpit, at the bar, or in the forum. The biographer is indeed fortunate who has elected to portray the life and work of such a man. The first line of the author's preface is significant. "Dr. Agnew lived his life without thought of a biographer." Had it been otherwise, the task of preparing such a work as that before us would have been more easily accomplished; but would it not have been less a labor of love? It is not improbable that we have in this book, whose pages are compiled from the memory of affectionate friends and associates, and from records preserved because of their intrinsic value, a better reflex of the life and character of the man than if from data found among his own papers.

MEDICAL NEWS.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from March 20 to April 20, 1894.

Leave of absence for one month is hereby granted Capt. Ogden Rafferty, Assistant Surgeon, with permission to apply for an extension until the 20th of May next. Par 1, S. O. 30, Dept. of California, March 30. 1894.

The following named officers of the Med. Dept. will report in person for temporary duty until further orders, as follows: First Lieutenant Charles Willcox, Assistant Surgeon: to the Commanding Officer, Angel Island, Cal. First Lieutenant Charles E. B. Flagg, Assistant Surgeon: to the Commanding Officer, Alcatraz Island, Cal. Par. 2, S. O. 30, Dept. of California, March 30, 1894.

Capt. Edward C. Carter, Assist. Surg., will proceed at once to Fort Spokane, Wash., and report to the Commanding Officer for temporary duty. Par. 1, S. O. 50, Dept. of the Columbia, March 31, 1894.

First Lieutenant William E. Purviance, Assist. Surg., is relieved from duty as member of the general court-martial appointed to meet at Fort Sherman, Idaho, by Par. 2, No. 46, from these headquarters. Par. 2, S. O. 50, Dept. of the Columbia, March 31, 1894.

First Lieutenat W. E. Purviance, Assist, Surg., U. S. A., and one member of the Hospital Corps, to be designated by the Commanding Officer, Fort Sherman, Idaho, will attend the troops on the contemplated march in changing station from Fort Sherman, Idaho, to Fort Spokane, Wash. Upon completion of this duty, Assist. Surg. Purviance will return via Davenport, thence by rail to his station. Par. 1, S. O. 52, Dept. of the Columbia, April 3. 1894

Major David L. Huntington, surgeon, Medical Director of the Dept., will proceed to Forts Marcy, Stanton, Wingate, Apache and Whipple Barracks, for the purpose of making the inspections contemplated in A. R.1662, and upon completion of the duties assigned, will return to his proper station. Par. 3, S. O. 18, Dept. of the Colorado, April 3, 1894.

First Lieutenant Charles Willcox, Assist. Surg., is hereby relieved from temporary duty at Angel Island, Cal., and will rejoin his proper station, The Presidio of San Francisco Par. 1, S. O. 34, Dept. of California, April 9, 1894.

Captain William R. Hall, Assist. Surg., is relieved from further duty in this department, to enable him to comply with the requirements of Par. 9, No. 69, Headquarters of the Army. Par. 1, S. O. 37, Dept. of Califarnia, April 14, 1894.

Captain William L. Kneedler, Assist. Surg., will, in addition to his present duties, perform that of attending surgeon in this city until further orders. Par. 2, S. O. 37, Dept. of California, April 14, 1894.

First. Lieutenant Charles Willcox, Assist. Surg., will report at the cavalry camp near Gilroy, Cal., on May 12th, and will accompany Troop C, as Medical Officer, to the Yosemite National Park. First Lieutenant Charles E. B. Flagg, Assist. Surg., will report at the cavalry camp near Gilroy Cal., for duty on June 1st, and will accompany Troop B, as Medical Officer, to the Sequoia National Park. Par. 1, S. O. 40, Dept. of California, April 20, 1894

So much of Par. 8, S. O. 60, March 12, 1894, from A. G. O., as relates to First Lieut. Harlan E. McVay, Assist. Surg., is amended to direct him, on being relieved from duty at San Carlos, Arizona, by First Lieutenant Straub, Assist. Surg., to report in person to the Commanding Officer. Fort Huachuca, instead of Whipple Barracks, Arizona Territory.

Captain William R. Hall, Assist. Surg., is relieved from duty as attending surgeon and examiner of recruits at San Francisco, Cal., to take effect upon the completion of his examination for promotion, and will then report in person to the Commanding Officer, Whipple Barracks, Arizona Territory, for duty at that post.

Par. 2, S. O. 68, A. G. O., is so amended as to direct First Lieutenant Harlan E. McVay, Assist. Surg., on being relieved from duty at San Carlos, Arizona Territory, by First Lieutenant Straub, Assist. Surgeon, to report for duty at Angel Island, Cal., instead of Fort Huachuca, Arizona, Ty.

The leave of absence granted Capt. Ogden Rafferty, Assist. Surg., is extended eighteen days.

So much of Par, 13, S. O. 79, A. G. O., as relates to Major Peter J. A. Cleary, Surgeon, is so amended as to direct him on being relieved from duty at Fort McPherson, Georgia, to report for duty at Fort Wingate, New Mexico, instead of Fort Custer, Montana, for duty at that post. to relieve Major Washington Matthews, Surgeon. Major Matthews, on being so relieved, will repair to Washington City, and report in person to the Surgeon-General for temporary duty in his office.

Leave of absence for twenty-one days, to take effect on or about April 14, 1894, is granted Major Charles L. Heizmann, Surgeon, U. S. Army.

By direction of the President, Lieutenant-Colonel Samuel M. Horton, Deputy Surgeon-General, will report in person to the President of the Army Retiring Board, at San Francisco, Cal., for examination by the board.

ITEMS.

Searby, Zeilin & Co.—The partnership heretofore existing between W. M. Searby and W, S. Zeilin has been dissolved. The pharmacy at the corner of Sutter and Stockton streets will be continued by Prof. Searby.

Dr. E. Johansen has removed his office from 112 Mason street to 203 Taylor street, San Francisco, Cal. Hours: 11:30 A. M. to 1:30 P. M., and 6:30 to 7:30 P. M.

Occidental Medical Times.

Vol. VIII. JUNE, 1894. No. 6.

THE DECLINE OF MATERNITY; ITS CAUSES AND ITS REMEDY.

By David Powell, M.D., Marysville, Cal.

Read before the California Northern District Medical Society.

It is said to be the ambition of every French woman to become the mother of but one child. A glance at the vital statistics of recent United States Census Reports would seem to justify the inference that the women of our own country, unlike their sisters of the French Republic, would willingly forego the responsibilities, pain, and perils of motherhood altogether, and be content to live without offspring. The decrease of the rate of increase of population began many years ago, both in Europe and America. Dr. Horatio Storer, of Boston,[1] some time ago, stated that the increase in Sweden had lessened by one-ninth in 61 years; in Prussia by one-third in 132 years; in Denmark by one-fourth in 82 years; in England by two-sevenths in a century; in Russia by one-eighth in 28 years; in Spain by one-sixth in 30 years; in Germany by one-thirteenth in 17 years; and in France by one-third in 71 years. In the United States the decrease has been still more marked, the natural increase of population having decreased from 28.2 per cent. from 1831 to 1840, to 22.78 per cent. from 1871 to 1880; while during the ten years from 1860 to 1870 the natural increase was only a little over 15 per cent., showing a falling off of nearly 13 per cent. in 30 years.

The total increase of population in the United States since 1830 has averaged about 32 per cent. every ten years; but the increment has been largely due to immigration, and it is a note-worthy fact that in many localities the natural increase has occurred to a very large extent among the foreign element. The average size of families in this country, as well as in Europe, has for many years grown smaller and smaller. In England the average number of children to each marriage, in 1885, was 5.2; in Austria 4; while in the United States, in 1880, the average number of children to each family, including all under 21 years of age, was only 2.51. Since the above dates the birth-rate in most countries has steadily declined, and at the present time in France the number of births to each marriage is but a little over 2 per cent.; and in Ireland, which is first of all countries in fruitful marriages, it is less than 5.5 per cent. There has also been observed in many countries, in connection with lessened birth-rate, a diminution of the average stature, a decline of physique, and a very marked increase of mental and nervous diseases.

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[1] American Journal of Science and Arts.

Although the above data are incomplete and imperfect, yet we are forced to the conclusion that among the better classes, at least, of all nations, the decline of maternity increases with each generation; and while the disturbing influences of unfruitful marriages have not thus far, perhaps, played any very important part in the fluctuations of the populations of different countries, yet the statesman must view with alarm their ultimate effect, not only upon population, but also upon the prospective deterioration of race, and the physical, moral and intellectual lowering of national character which must eventually result.

But the political economist does not consider this subject from the standpoint of the statesman, the sociologist, or the physician. He looks upon the decrease of birth-rate in a community as an effort of natural forces to restore equilibrium; that is to say, when the increase in the population of a community approaches the limits of subsistence, or passes beyond the point where a competent subsistence is provided to maintain the whole population in health and strength to labor and live in comfort, then the "procreative force" meets the "positive checks" of restraint, of diversified economic wants, and even of famine, pestilence and war. He goes farther, and contends that, in as much as unrestricted increase would soon carry population to the point of industrial distress, and that families could be no longer supplied with what is necessary to keep their members in health and comfort, it is necessary for the happiness and well-being of the present, as well as the generations that are to follow, that some potential check must act in restraint of increase, either by diminishing the number of the marrying class by encouraging celibacy among those who do not see their way clear to support a family; by discouraging early marriages, or by lessening the birth-rate within the married state.

These views are essentially the Malthusian doctrine, promulgated a century ago, and they have had the warm support of many eminent writers upon political economy in later years. Prof. Senior, the English economist, said: "Although we believe that as civilization advances the pressure of population upon subsistence is a decreasing evil, we are far from denying the prevalence of this pressure in all long-settled countries; indeed, in all countries except those which are the seats of colonies applying the knowledge of an old country to an unoccupied territory. We believe that there are few portions of Europe the inhabitants of which would not be richer if their numbers were fewer, and would not be richer hereafter if they were now to retard the rate at which their population is increasing." Still later. Prof. Walker, of Boston, said: "In France even the peasantry are so fully alive to the inexpediency of a rapid multiplication, and are so temperate and prudent, that the excess of births over deaths has been reduced to a minimum. 'Since two or three children give us sufficient enjoyment of paternity, why,' the greater number of Frenchmen argue, 'should we have more? With two or three children we can live comfortably, and save sufficient to leave our children as well off as ourselves; a greater number would involve curtailment of enjoyments both for ourselves and our children.' In the early history of the States of the American Union, the increase of population was everywhere encouraged by the fact that the country had not reached the condition of diminishing returns, but on the contrary, as is always the case before that condition is reached, foreign immigration and native growth in numbers alike added to the power and wealth of the several communities. Within the past twenty-five years, however, the rate of natural increase in the northeastern States has encountered a decided check, due to the rising standard of living in communities whose productive capabilities are already fully developed."

Such, in brief, are the views of political economists upon the subject of increase of population, and its relation to the consumption of wealth. But it seems to me that they are based more upon theory than upon facts and experience. If the checks to the "procreative force" were to operate only upon the poor and those unable to care for and educate their children, and the decrease in population thereby effected to find compensation in increased fecundity among the wealthier classes, there would undoubtedly be an economic gain. But it is a universal law that the poor increase faster than the rich, and that fertility is in inverse ratio to the means of support. The poor do not regard the burden of child-bearing. They do not devote much time to the investigation of the causes which lead to the condition of "diminishing returns;" to reflecting upon the "limits of subsistence," or whether the "productive capabilities" of the community are fully developed or not. The state of the population of Ireland previous to the great famine of 1846, and of India and China at the present time, clearly demonstrate the truth of Prof. Walker's assertion that there is not "sufficient virtue in economic forces to keep population above the plane of extreme misery if once it falls below the plane of comfort and decency. On the contrary, a moral weakness or recklessness is induced, which tends strongly and swiftly to carry population to the point of industrial distress."

The law of the survival of the fittest does not apply to mankind as it does to the lower animals. Among animals the offspring are cared for and protected with a fierce, instinctive, parental devotion, but only until the young are capable of providing for and protecting themselves. Then their lives become separated, and in the struggle for existence which follows, the weak and the deformed and the sickly succumb, while the fittest survive, growing larger and stronger generation after generation. But in the human family the conditions are greatly changed. The solidarity of parent and offspring, which in the lower animal is of brief duration, in human societies is lasting, and continues through life. The old and the young, the strong and the weak, are united by the natural instinctive bonds of kindred and self-sacrificing devotion to family ties. If poverty pinches, they all share its hardships; if privation or want overtakes the family, the frail and the weak are the last to feel its bitterness; if sickness falls upon one of its members, instead of being neglected he becomes the object of the tenderest care and solicitude of all; others will deny themselves that the wants and comfort of the invalid may not be overlooked. Thus, instead of the natural elimination of the weak and the worst, it is the best and the fittest who, from parental or filial love, "bare their breast to receive the blows of fortune."

The decline of maternity, then, in our own country and elsewhere, is found to be conspicuously greater among the better classes and the wealthy than among the laboring poor; and the checks to increase of population, whatever they may be, operate with the greatest force among the strongest and the best, and those most capable of rearing a numerous and vigorous offspring. It cannot be denied that the unrestricted increase of the family is sometimes an evil; but the evil of unnatural restraint and calculation is infinitely greater. It is destructive alike to the happiness and moral welfare of the family, and to the prosperity, growth, and progress of nations. Nature has endowed woman with strong conjugal affection, and has implanted in her a deep instinctive love of offspring. Can these natural impulses be thwarted without blunting the mother's moral sensibilities, and destroying those admirable qualities of mind and heart that have distinguished her—love of home and children, and unswerving devotion to all the hallowed associations of family ties?

Again, who can doubt that reluctant conception and loathful gestation have often marred the offspring, and that the ultimate effect of thus restricting increase would tend to produce in time a generation of weak-minded, sickly children, with impaired constitutions, and perverted moral perceptions—a race mentally and physically deformed. To my mind there are no arguments that the economists can advance, no reason which our modern civilization can assign, for the artificial checking of fruitful marriages that are not clearly controverted by a knowledge of the evils that follow all efforts, in violation of natural laws, to retard the increase of the world's population. And yet the natural increase in our own country even, with its almost unlimited resources—a comparatively new territory, and capable of sustaining a very much larger population than the present—is relatively decreasing year by year.

What are the causes? They are many, and in this brief essay I can only hope to bring to your notice a few which appear most prominently associated with the decline of maternity. Sterility is not uncommon among a considerable number of both sexes. Different observers have given the ratio of sterile to fruitful marriages from 1:10 to 1:8; and Mathews Duncan believed, from his researches, that in England fully 15 per cent. of all marriages were sterile. I have not been able to find sufficient data to estimate the proportion for the United States, but perhaps 1:10 would be approximately correct. These figures serve, at least, to show that fruitless marriages are far more frequent than they are generally supposed to be. The causes of sterility, which condition is understood to mean that one or both of the married pair is incapable of reproduction, are often obscure and difficult to determine; but are for the most part to be found in constitutional affections, nervous influences, and local diseases of the organs of generation.

But is sterility more common now than it has been in the past? In comparing the etiology of unfruitful marriages at present with previous generations, are the above factors more frequently observed, or do they assume, in their causative relation to this condition, greater significance than formerly? That our social conditions exert influences unfavorable to fertility in both men and women cannot be denied. Gross violation of nature's laws, whether in matter of dress, habits, and customs of life, or in excessive expenditure of nervous energy—which our present civilization undoubtedly entails, especially upon young women—cannot fail in time, among other harmful consequences, to diminish procreative capability. The early education, neglect of physical culture, the social environments of the girl, and the demands of fashionable life, are too often productive of diseases and conditions which render her, later on, incapable of enjoying the happiness and blessings of maternity. The early indiscretions and unbridled excesses of youthful manhood, too, are not infrequently followed by incurable impotency and sterility in men. So that the customs of the age, our artificial mode of life, our proneness to neurotic and functional affections, our habits and surroundings—differing widely as they do from the conditions under which former generations lived—all conspire to derange the functions of reproduction and tend to produce sterility.

But a more potent cause of the decline of maternity in the present generation is found, as I believe, in fruitful marriages—marriages in which, from various motives, restraint limits the number of offspring. In the days of our forefathers matrimony and the growth of families were assigned to the care of the affections; men and women were governed wholly by natural impulse, and, like the Patriarch of Israel, regarded with commendable pride their dozen children. Calculation and unnatural restraint were not thought of, nor were they given to the study of economics in its relation to the effects of increasing population upon the best interests of the community. Their daughters were not so well educated in the physiology of their sex as are the young ladies of modern times—were not so efficiently taught to "know themselves," nor initiated into those mysteries which are calculated to prepare them so well for all the exigencies of married life.

Of late years the education of young married women, too, in these matters is not neglected. There is not a community in the whole length and breadth of the land that is not periodically visited by some self-constituted teacher or so-called lecturer—usually some female adventuress—whose special mission it is to diffuse a certain kind of knowledge designed to "reform the married relations." What is the result? Women learn to look upon maternity as an intolerable burden; to regard children as a nuisance; to consider a large family as a disgrace tolerated only by the poor and the ignorant. They are taught how they may avoid the privation of social and fashionable pleasures to which gestation and the responsibilities of motherhood would subject them, and learn many arts which they subsequently find useful in their selfish—nay, sometimes criminal—efforts to escape maternity.

The Malthusian idea is more in accord with public sentiment than it was at the beginning of the present century. Not because it has been demonstrated that the industrial interests, and general well-being of nations are endangered by prospective excess of population, but because the doctrine is more in touch with the prevailing notions of the times. Early marriages are not common. Young men in ordinary stations of life cannot afford to marry; they must wait till their fortunes are made. This is an age of deliberation and calculation, and marriage is oftener controlled by social or business considerations than by affection and sentiment. Parents will not consent to the marriage of their daughter until the suitor has attained prominence in business, social distinction, or is successful in his profession. Few men reach the goal of success before middle age, and matrimony so late in life is not always congenial, and is seldom prolific in offspring. The doubtful expediency and wisdom of assuming marital relations before the husband can see his way to support wife and children, will be readily conceded; but neither should he wait till his fortune is assured. The happiest marriages and largest families are often found among those who are ever struggling against the adversities of poverty.

Another cause of decrease in marriages, and consequent decline of maternity, is the deplorable laxity of public morals. Licentiousness has always been a strong hindrance to matrimony, and so long as law and public sentiment do not punish concubinage, and ostracise those guilty of unlawful cohabitation, the careless life and freedom of the bachelor will continue to be preferred by many to the responsibilities and obligations of lawful wedlock.

Finally, as a direct result of some of the causes enumerated—including hatred of offspring, unmotherly objection to a large family, overwhelming devotion to fashionable life and social amusements, consideration of the cost of rearing children, and aversion to marriage—we can not pass unnoticed the hideous crime of feticide. Repugnant as it is to every social and moral sentiment, we can not deny its increasing prevalence. It is not a vice of ignorance and poverty. On the contrary it is far more common among the better educated and wealthier classes—in which, moreover, we find the greatest decrease in the average birth-rate. It is painful to acknowledge that candor compels us to mention this infamous crime as one of the causes—perhaps, indeed, one of the principal causes—of the decline of maternity in the present generation. What a blot upon a Christian civilization! It is gratifying to observe that, occasionally, judge and jury are so impressed with the enormity of the offense, that tardy justice is permitted to overtake the miscreant who, by generous distribution of vile books and pamphlets, and liberal patronage of vendible newspapers, audaciously heralds his iniquitous practices, and lures his victims to their moral and physical ruin.

The causes of the decline of maternity are so numerous, in different countries and communities so variable, and for lack of accurate statistical records so difficult to determine with any degree of precision, that an attempt to formulate a remedy is obviously impracticable. For many of the causes the remedies, it is true, are self-suggesting; but their practical application would involve a revolution of customs, habits, thoughts, and morals, the very possibility of which would imply the dawning or near approach of the millenium.

If diversified and increased economic wants, and desire for a higher standard of living, act in restraint of population, the remedy lies in checking the expenditure of the wealth of the country upon indulgences, and tastes, and luxuries, which at best are without any real benefit, either to the individual or to the community. A standard of living, beyond necessities and comforts, which taxes a community to its full productive capacity, and which demands the retard of increase in numbers to prevent population from being carried to the point of misery and distress, is too high, and often not only without beneficial effect, but positively injurious, and destructive of moral, intellectual, and physical power. It is said that in Great Britain alone $900,000,000 are spent annually for alcoholic beverages. It is probable that in this country even a larger sum is similarly expended. What effect would a wiser consumption of wealth have upon the economic life of these countries?

Aversion to marriage and unmotherly objection to offspring are not natural attributes of womanhood. They are, on the contrary, directly opposed to every instinctive impulse of a woman's nature. Yet how common in these days to find intelligent, educated women clamoring for recognition in pursuits, and vocations, and "rights," the possession of which would of necessity debar them from the exercise of the ideal privilege, the divinely appointed object of their being—reproduction of their kind. Is not the knowledge that the desire exists to sacrifice the sacred duties of motherhood for the pleasures of fashionable life; that there is a disposition to forsake the genial serenity and happiness of domestic life for turbulent affairs of business or state, to desert the cradle for the ballot-box, enough to create apprehension for the future safety and destiny of the race?

Yet I confess that I do not know what power may or can be invoked to overcome these perverted, unwomanly sentiments—sentiments encouraged in few by ambitious caprice; in many by the sole desire of enjoying, without the hindrance which maternity would interpose, the pleasures and indulgences of conventional society.

A purer and more exalted conception of the purposes of marriage; a better appreciation of the mutual obligations it imposes; probity of life, and the cultivation of abstemious and frugal habits, and domestic attachments among men; the higher education; a more intelligent contemplation and observance of nature's beneficent laws;

and the greater advancement of an ideal Christian civilization, may, in the future, overcome erroneous ideas, customs, and habits of thought; lead to a more natural, rational, and healthy spiritual and physical existence, and to the transmission of sounder theories and doctrines of social science to an increasing and more enlightened posterity.

Peri Block.

BRIGHT'S DISEASE AND ANESTHETICS.

By F. B. Carpenter, M.D., San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

The term Bright's disease, though not framed upon anatomical or pathological conditions, is perhaps as comprehensive as any single expression that can be applied to this very complex disease, involving so many tissues.

Bright's disease is not only a disease of the kidneys, but a disease of the heart, and vascular system as well. Some have supposed it to be due to a diseased condition of the blood, others of the sympathetic nervous system. We all know where it ends, but no one as yet knows where it begins.

The nephritis is probably not the primary disease, but rather secondary to a chronic endarteritis, since it has been observed to follow in regular course upon the symptoms and manifestations of endarteritis, when disease of the kidney not only had not been suspected but could not be demonstrated. Usually, however, the two conditions are associated, and when a patient presents the evidence of arterial degeneration, even in its early state, diseased kidneys, either present or prospective, must always be suspected.

When a patient is found to have hypertrophy of the heart with atheromatous valves or arteries, which may result in hemorrhages upon the mucous or serous surfaces, irregular heart action, palpitation, vertigo, and headache; and more especially if there be edema or bronchitis, with muscular debility, and a train of nervous symptoms, such as ill-temper, loss of memory, or even insanity. When these symptoms are grouped together, it behooves one to look to the kidneys for an explanation.

We may be disappointed in the search for albumin, or even for renal casts and epithelium, but we will generally be safe in making a diagnosis of Bright's disease. The presence of albumin is by no means constant, and when found is, if considered by itself, of little diagnostic value, as it may result from cystitis, from renal congestion due to pressure upon renal veins by the pregnant uterus or other tumor, from ingestion of food, muscular exercise, febrile action, surgical operations, and many other transient causes. But the albumin disappears when the cause has been removed. Again, patients with acute nephritis sometimes pass large quantities of albumin with hyaline and granular casts, yet make a complete recovery.

Kelly has shown that hyaline and granular casts are sometimes present after abdominal operations, and subsequently disappear. It would seem from this fact that the anesthetic is in some measure responsible for their presence. He has also confirmed the statement that albumin and casts, often present with large abdominal tumors, are due to pressure of the tumor upon the ureters or renal veins, and it usually disappears after removal of the tumor.

Albumin appearing after operation is usually due to cystitis occasioned by concentrated urine. If albumin is suspected to be due to some bladder complication its source is easily determined by thoroughly emptying and irrigating the bladder, and then examining the urine that collects in the next few minutes. If one kidney is suspected of being diseased this may be determined, in the female, by catheterizing the ureters after Kelly's method, and examining the urine from each kidney separately.

If albumin is shown to be of renal origin, its presence is always significant of changes in the secreting tissues of the kidneys. If associated with tube casts and low specific gravity, with normal or increased quantity of urine, the surgeon must proceed with caution, and before operating see that bowels and skin are in good condition to eliminate products, which, after operation, the kidneys may not be able to care for.

The autopsy records of most hospitals show deaths from suppression of urine following anesthesia for surgical operations. The previous history of many of these cases show that examination revealed no sign of albumin, no casts, no renal epithelium, and yet the autopsy book shows that they had contracted kidney.

Most operators of much experience have had the misfortune of having patients die from suppression of urine from one to four or five days after anesthesia either by chloroform or ether; and in these patients Bright's disease was not suspected until revealed at the autopsy. A diagnosis of contracted kidney cannot be made in many cases by urinalysis, and heart and arteries should be carefully examined for atheroma or enlarged ventricle. If the urine is of high specific gravity, scanty and highly colored, with albumin or casts, and the heart hypertrophied, with pulse of high tension, the probabilities are greatly in favor of disease of the kidneys, and also of an autopsy following operation.

The cause of suppression of urine following anesthesia is as yet a matter of speculation. It has been supposed to be due to the suspension of oxidation caused by the surcharge of the blood by ether or chloroform, and by deprivation of oxygen during its administration. (Porter.) Carstens thinks that it depends upon poisoning of the solar plexus. Others attribute it to refrigeration of the body from exposure, rather than to the anesthetic. Again it is attributed to free sweating and unloading of the blood vessels of serum, thus concentrating the blood, and making it unnecessary for the kidneys to excrete water, consequently the solids remain in the circulation, uremia and death resulting.

The actual cause may be found in the direct irritant effect upon the epithelial cells of the few remaining malpighian tufts of the foreign and volatile vapor circulating in the blood, and seeking every avenue of escape. Although both anesthetics are rapidly eliminated, it is a matter of common observation that the odor of ether, more than chloroform, can be detected in the patient's breath many hours after consciousness has returned, and while constantly diminishing in quantity in the circulation, nevertheless, if it be, in any degree, an irritant to the renal cells, this action is continued until it is entirely eliminated, which may be several hours. Authorities all agree that suppression of urine follows administration of ether in a certain number of cases, but many instances are reported in which suppression has also occurred after the use of chloroform in chronic parenchymatous and chronic interstitial nephritis.

Ether has been looked upon as the safer anesthetic, probably because death on the table has been less frequent with it than with chloroform. Death on the table is doubtless due to paralysis of the cardiac or respiratory centers, and inhalation of a large quantity of anesthetic seems not to be necessary. The more remote death due to uremia, after prolonged and profound anesthesia, while it may indirectly result from the action of the poison upon the nerve centers, is ostensibly due to retardation of the excretory functions of the various eliminating organs. Doubtless the quantity of the anesthetic is important and should receive due consideration in all cases of anesthesia, but especially so when the kidneys are known or suspected to be diseased.

Ether, like chloroform, during prolonged anesthesia, depresses the heart, hence in case of chronic Bright's disease, chloroform should receive the preference, if operation be imperative, because anesthesia can be more quickly induced, more easily maintained, than with ether, and with a very much smaller quantity of the drug, while during its administration a much larger proportion of atmospheric air is permitted, by which the natural functions of life are maintained.

The hypodermic use of morphine before giving either anesthetic is certainly rational, notwithstanding the fact that morphine temporarily diminishes the secretions. It does not totally suppress them, and the anesthetic does; hence substituting morphine for chloroform diminishes the risk of suppression by diminishing very materially the amount of anesthetic required. The previous use of ethyl bromide may prove an advantage in those hazardous cases, as it produces unconsciousness and muscular relaxation much more quickly than chloroform, with which the operation may be continued.

If the case is one of undoubted contracted or large white kidney, avoid operation entirely, if possible, or use local anesthesia. If albumin and casts are due to pressure of an abdominal tumor, and no cardio-vascular changes can be found, it is comparatively safe to anesthetise. Select chloroform, and use salines soon after operation, that the bowels may relieve the kidneys of the work. If albumin and few hyaline or granular casts are found, use as little anesthetic as possible and operate quickly. If the urine be scanty, of high color, with high specific gravity and cardio-vascular changes, beware!

916 Market street.

UTERINE FUNGOSITIES.

By E. J. Boyes, M.D., Oakland, Cal.

Read before the Alameda County Medical Society.

The condition chosen for this evening's discussion embraces the various benign vegetations of the endometrium. Histologically it is agreed that they are identical in structure with the mucous membrane of the uterus, being composed of connective tissue, glandular and fibro-plastic elements, and covered by the epithelium peculiar to the uterine mucous lining. Their gross pathological appearance presents varied forms, from fungoid thickening or spongy folds to club-shaped polypi, or soft, semi-sessile glutinous bodies, varying in size from a millet seed to a pea. No one surface seems particularly favored, but these villosities are limited to the cavity of the uterus proper, the cervical canal being the province of enlarged Nabothian follicles and mucous polypoids.

Having thus recalled to your minds the condition we wish to consider, I shall now discuss the causes that may lead to it. This will be greatly facilitated if we bear in mind the functional, nervous, and vascular energy of the reproductive apparatus. For, in this light, we have distinctly before us the all-important fact that congestions are readily instituted and easily perpetuated in the womb and its adjuncts.

Here, then, is the keynote of the etiology, as well as of the treatment, and it follows that every cause of prolonged engorgement may also be written as occasion for "endometritis hyperplastica." Further, it is well known that return to normal size and consistency occurs with remarkable promptness when the irritating factor is eliminated, always provided the affection has not proceeded so far as to produce cirrhotic change.

Toward this end: (1) Laceration of the cervix must be repaired. (2) Displacement must be remedied. (3) Support given to prolapse. (4) Tumors and growths removed. (5) Chronic endometritis patiently treated.

The presence of fungosities in the womb is usually announced by uterine hemorrhage of greater or less severity, which, indeed, may be the only expression of the affection. However, their existence can be demonstrated with certainty only by the use of the curette, as first suggested by Récamier. And if possible the blunt curette of Thomas should be made to suffice, resort being had to the sharp instrument devised by Sims only when conditions demand it, because, while more efficient, it is not without risk. The spoon-curette recommended by Simon, will at times prove serviceable, as will also the small fenestrated polypus forceps, as suggested by Goodell.

Having by these agents removed the growths, it is desirable to apply some such antiseptic alterative to the cavity as strong tincture of iodine. In illustration of this treatment I have here appended notes of several cases in my practice.

CASE I.—Mrs. E. S——, of Virginia, Nevada, consulted me in regard to exhausting hemorrhages, that were increasing in frequency and amount. She had three children, and admitted a miscarriage six months previous. The cervical canal was dilated with tents, and the blunt curette thoroughly used, with apparent benefit. The womb was swabbed at that time with tincture of iodine. She returned to me, however, in a few weeks in quite as bad a condition. The curette was again used, fuming nitric acid applied to the endometrium through an applicator, and the vagina tamponed. On both occasions I removed fleshy masses that on examination seemed to be vitalized growths of placental tissue, which in all probability they were, and were kept from decomposing by becoming grafted on to the local circulation, in the form of vitalized tufts. Recovery was complete, and menstruation became regular and moderate.

CASE II.—Miss A——, single, aged 25, came to me in October, 1893, for relief from a persistent and at times alarming menorrhagia. Menstruation, at all times free, had for six months or more increased so as to seriously deplete the system. Examination through a Sim's speculum, the cervix well drawn down by a vulsellum forceps, revealed a relaxed exsanguine vagina and a patulous os, as well as an enlarged and softened cervix. The sound was passed and developed a three inch cavity, notably increasing the hemorrhage. Here, as in most cases, it was possible to pass a small Thomas curette without resorting to dilatation. However, with the aid of Ellenger's dilator, I made the canal more patent to admit the larger instrument, and so expedite the operative procedure. Previous to doing so, the vagina had been washed out with a solution of creolin, and the instruments rendered thoroughly antiseptic. Moreover, any instrument that I use inside the uterus, is invariably first soaked in pure carbolic acid for a minute or two, as an extra precaution, a trick learned from my friend Dr. Crowley. Carefully curetting the entire endometrium, from the fundus downward, I dislodged at that time a considerable number of these growths in the form of gelatinous masses mixed with blood and debris. That accomplished, the cavity was swabbed with equal parts chloral and iodine, and the vagina tamponed with iodoform gauze. Twice, subsequently, the same proceeding became necessary for the relief of partial relapse, and on each occasion, a similar result followed curetting. Good results ensued and my patient was continued on internal treatment of arsenic and strychnine tablets, to which iron was added later. Up to date she is quite recovered and continues to gain in weight and strength.

CASE III.—Mrs. H. D——, a lady of highly neurotic temperament, presented a complication in the form of a perineal laceration extending into the rectum, giving rise to prolapse of uterus and bladder to a moderate degree, which untoward condition, with their train of evils, she had endured till several smart hemorrhages demanded interference. The womb and its cavity were enlarged, and the os quite patent. The blunt and semi-sharp curettes were both used here, and a large amount of muco-glandular detritus obtained from the womb, the scrapings being, as they often seem, amorphous. Here, as in all these cases, the entire endometrium was methodically and diligently scraped, with due care, and the cavity then treated with strong tincture of iodine. An iodoform gauze tampon was added, and instructions for two days' rest in bed. Shortly after, with the assistance of two of my *confrères*, the perineal body was restored, and from then the patient's recovery was rapid and complete. One year later she was still in perfect health.

The procedure in these cases may be summarized as follows:

1. Precede the operation by a vaginal irrigation with creolin or lysol 1:100.
2. Use the Sim's speculum in the semi-prone position, the cervix well drawn down by a vulsellum forceps, the operator in a good, easy posture, and with direct light.
3. Dilate, if necessary, with Ellenger's dilator, to insure free drainage.
4. The blunt and semi-sharp curettes usually suffice. For placental tufts, the finger is the best means.

5. Anesthesia is not usually requisite, as pain and shock are not great in the average case.
6. Antiseptic irrigation should conclude the operation.
7. Iodoform gauze is the best tampon material.
8. The patient should retire to bed for 24 hours.

1068 Broadway.

DIPHTHERIA.

By O. STANSBURY, M.D., Chico, Cal.

Read before the California Northern District Medical Society.

In presenting this paper for the consideration of the Society, it is not my object to note any new facts concerning the nature, cause, and treatment of diphtheria, but rather to call attention to careful observations made from a standpoint of practical experience; and I shall give you something which, while it may not be startling, will, I hope, be not entirely devoid of interest regarding this dread disease.

Etiology.—At the present stage of our knowledge the disease is regarded as microbic, and the peculiar bacillus, which is supposed to be responsible, was first discovered by Klebs, and more fully studied by Loeffler. Hence the name, Klebs-Loeffler bacillus has been applied. This bacillus fastening upon the mucous membrane of the throat and nares, soon elaborates a poison, which is rapidly taken up by the lymphatics and blood-vessels, and is speedily conveyed to every portion of the system. This blood-poisoning, from which so many of the victims die, is due to the poisonous products of the Klebs-Loeffler bacillus.

"Rou and Yersin state[1] that recent investigations confirm the the belief that the bacillus itself is comparatively innocuous, but the poisonous substance produced by the bacillus, and separated from it by filtration, innoculated in dogs and sheep produces paralysis, such as occurs in human diphtheria. This poison isolated from the bacillus by filtration and injected under the skin of rabbits and guinea pigs was very fatal. While the filtered liquid containing the toxic agent causes the poisonous symptoms, it does not produce the pseudo-membrane."

These observers have made the remarkable and interesting discovery of a benign bacillus, which is apparently identical as regards morphological characters with the Klebs-Loeffler bacillus. They state they have found it not only in the mouths of healthy children in Paris, but in a distant village near the sea where diphtheria had not occured within the "memory of man." In this isolated locality they found it in the mouths of 26 out of 50 children. They believe that this benign organism is the Klebs-Loeffler bacillus deprived of its virulence; but they have been unable to produce its transformation into the genuine diphtheria bacillus, or the reverse. They believe, however, that this transformation is possible, and that it does occur. It has been stated that this benign bacillus has been found in individuals recently cured of diphtheria. Perhaps foul air and insanitary conditions are agents by which this transformation of the mild into the pathogenic bacillus is accomplished.

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[1] Sajous' Annual, for 1893.

Summing up the matter, the conclusions arrived at were practically as follows: "While justified in attributing the severe constitutional symptoms in toxic diphtheria to the poison elaborated by the Klebs-Loeffler bacillus, yet in order to explain all the phenomena observed in severe diphtheria, we must also direct attention to the microörganisms associated with the Klebs-Loeffler bacillus, especially the staphylococcus and streptococcus pyogenes. The microbes are found in the pseudo-membrane, and the adjacent inflamed surface."

Diagnosis.—It is all important that this should be made as early as possible. This is usually easy after the disease has continued for 24 hours, yet at times this may be somewhat difficult. With the present advanced stage of our knowledge in regard to the cause of the disease, we are aware of the fact that we can have a pseudo-membranous formation which is not diphtheria, and that only the microscope will clear up the doubt. This makes it exceedingly difficult for those of the profession who are not experts with that method of diagnosis.

A failure to diagnose the disease often leads to dire results, and to the propagation to others, and injury of the reputation of the physician. I am aware it has been the custom in times gone by to regard every case of pseudo-membranous formation of the throat as a case of diphtheria, and no doubt this is a safe rule to adopt. But it will not hold good, and from it has arisen the claims we so often hear from some members of the profession who extol a certain remedy, and assert with its use they have "never lost a case." I am free to confess I have not been so successful.

The safest plan, in these doubtful cases, is to reserve an opinion until such a time as the disease is fully developed, giving the patient in the meantime the benefit of the doubt, and treat as diphtheria. Follicular tonsillitis is often difficult to distinguish from true diphtheria; in some mild cases this seems impossible. Osler claims: "In diphtheria the exudation forms a definite uniform patch on a deeply congested mucosa. In follicular tonsillitis, when the exudate oozes and the material from the crypts coalesces, it may be extremely difficult to make a diagnosis. If the process is confined to the tonsils the nature of the case may be dubious; if, however, it extends to the pillars of the fauces, and if laryngeal symptoms develop, all doubts are removed. Occasionally the true character of the disease is not manifested until a paralysis is developed during convalescence."

The report of a few cases from practice will demonstrate the difficulties encountered. On the 7th of October, 1893, I was called to see a child 5 years of age, in a family where there were five children in all, ages ranging from 2 to 12 years. Found my little patient with slight fever, and a slight grayish-white formation upon both tonsils; the fever lasted about 24 hours. In 48 hours every vestige of the deposit had disappeared. There was little glandular swelling; there was slight watery discharge from the nose, which was promptly treated and soon ceased.

On the third day from my first visit a second child, a boy of 12 years, had a slight deposit on both tonsils, which had disappeared in 36 hours; in this case no glandular swelling existed. A rapid recovery took place in both of these cases, and there were no after effects. The other children were sent from home the day of my first visit.

On the 12th of the month, seven days from my first visit, the youngest, aged 2 years, was brought home with a high fever, and evidence of gastro-intestinal trouble. A brisk purge and enema brought away large quantities of grape skins and seeds, with rapid amelioration of all the symptoms. The throat was examined, and no evidence of deposit or other trouble found. On the 14th, I visited the house and found a beautifully marked and unmistakable case of diphtheria, which lingered for a number of days, but finally recovered, with no bad after results. The fourth case, aged 10 years, returned home on the 12th; on the fourth day after her return she complained of feeling badly, with some fever. Within 12 hours she had an extensive membranous formation on both tonsils, which rapidly extended to pillars of fauces, uvula, and soft palate, with grave constitutional symptoms. This was quite a tedious case, with final recovery.

My object in reporting these cases *in extenso*, is to emphasize the fact that had it not been for the last two, the nature of the two first would have remained in doubt. The fifth child of the family remained away from home for a number of weeks, and escaped the disease.

Prophylaxis.—The duty of the physician is to see that no children go to school from a house where there is diphtheria; this is more easily done in a country town than in large cities; but it should be enforced as far as practicable. It is a fact worthy of serious consideration that, while other contagious diseases have decreased within late years, diphtheria has been on the increase. This is due to the great difficulty of quarantining those who have been exposed to the disease, and those who may have the disease in a light form, and receive treatment at home with some vaunted specific which "was never known to fail." Unless closely watched these cases will be permitted to go to school before they are entirely free from the disease, and it will be propagated in that manner. At other times the disease assumes such a mild form that little attention is paid to it, while with scarlet fever, measles, and other eruptive diseases, the external evidences are such that they are more apt to be noticed. This is a difficult matter to reach, and I would particularly like to hear the best methods of preventing dissemination of the disease especially dwelt upon.

In the sick room all articles and utensils used should be thoroughly disinfected—clothing, bedding, bedsteads. Everything which is not essential should be removed, and a bare floor can be cleaned easier than a carpeted one. For the clothing and bedclothing I am accustomed to use a solution of sulphate of zinc, 8 oz.; carbolic acid, 4 oz.; add this to 3 gals. of water. Soak clothing in this solution for 24 hours, then boil. A small quantity of the solution can be placed in the vessels for excreta. The discharges from the nose and mouth should be received on rags and burned at once. Physicians in their attendance on these cases should use every care, as the examination of the throat renders one liable to have the sputa lodge on the face, beard, or clothing. The safest plan is to protect clothing with a sheet or blouse. Before leaving the house the face, hands, and beard should be bathed in some of the zinc-carbolic solution, or Labarraques solution, one part to five of soft water. Cases are on record where there were strong probabilities that the disease was conveyed by the physician to the members of the family.

The children of a family, where there is diphtheria, should receive careful attention. They should be made to use antiseptic sprays or gargles, and be put on the chloride of iron mixture mentioned under the head of treatment. In fact, nurses and physicians would do well to use some gargle, while attending these cases. With strict isolation and this kind of care, I am satisfied many cases can be prevented. The atmosphere of the room should be made as aseptic as possible by the vapor of the following mixture:

Acidi Carbolici,	
Olei Eucalypti	āā ℥i
Spts. Terebinthinæ	℥viii

Two tablespoonfuls of this in a quart of water in a shallow vessel, constantly simmering on the stove, will be found an excellent preparation. It has a very penetrating odor, is not disagreeable, and can be used with beneficial results.

The cleansing of a room after a case of diphtheria should be done in a thorough and systematic manner. The burning of sulphur without moisture is valueless. Where you have a carpet on the floor, go over it with a sublimate solution, 1:1000. After this, take up the carpet, clean it thoroughly, go over the walls, floors and ceiling with the sublimate solution, being careful to get into all of the corners and crevices. In like manner all the furniture should be treated. All playthings and books used by patients should either be burned or disinfected. Cases have been traced to books handled by a diphtheritic. After relaying the carpet, go over it again with the sublimate solution. You may finish with a thorough fumigation of sulphur, and see to it that there is plenty of moisture in the room while fumigation is going on. Finally, air the room well for two or three days. I speak minutely, as I have some experience in this matter, and attention to disinfection may save the life of some dear one.

Treatment.—Regarding the microbic origin of the disease, and its local character at first, the rational treatment that would suggest itself would be the use of some remedy which has power to destroy the microbe and its poisonous products, and that also has a solvent action on the membrane. At the same time, it should be of such a mild, non-irritating nature as not to produce a wider field for the absorption of the poisonous products of the bacillus.

My experience convinces me that we are not to look for a specific in the treatment of this disease so much as to see that the remedies prescribed are thoroughly and conscientiously applied during the first 48 hours. The hand bulb atomizer I regard as far preferable to any other mode of making local applications, particularly with young children. With this method the liability to produce vomiting is reduced to a minimum, which is a very important consideration, when we consider we have to deal with a disease which will frequently tax the strength of the patient to the utmost.

The prescription which I have used with satisfaction, and can highly recommend as possessing all the powers just mentioned, is as follows:

℞.	Olei Eucalipti	ʒii
	Sodii Benzoat.	ʒi
	Sodii Bicarbonatis	ʒii
	Aquæ Calcis	Oi

Sig. Use with hand bulb-atomizer from 3 to 5 minutes every half hour, or with steam atomizer almost constantly.

When you can use this early, before the system has become poisoned, you will get excellent results. This, with the insufflation of sulphur every three or four hours, comprises all of my local treatment, excepting where there is much odor and the membrane is very thick and gangrenous; the peroxide of hydrogen (Marchands'), with an equal quantity of glycerine, can then be used to advantage. No force should ever be applied in removing membrane. This I wish to emphasize.

In the laryngo-tracheal variety of the disease, the steam atomizer, with the alkaline mixture already mentioned, should be used every 15 to 30 minutes. When breathing is very difficult, with croupy cough, an occasional dose of the yellow sulphate of mercury, 3 to 5 grains every 15 minutes, until free vomiting is produced, will often have a wonderful effect, and frequently save your patient in seemingly hopeless cases. The nose should receive careful attention. At the first evidence of a discharge or stoppage, treat promptly. Syringe frequently with Dobell's solution diluted with an equal quantity of warm water; with very young children this should be further diluted. Instruct the nurse how to syringe by holding the syringe in a horizontal position, and throw in with some force. A hard-rubber syringe of good size (half to one ounce), that can be used with one hand, and with the regular nasal point, is the only kind that can be used with success.

The tincture of the chloride of iron has stood the test of years and, I think, is generally recommended. Give it in good doses, frequently repeated. The formula I am partial to, and that is recommended by J. Lewis Smith, is as follows:

Tr. Ferri Chloridi	ʒ iii to iv
Potassæ Chloratas	ʒ ss
Acidi Hydrochlor, deluti	mx
Syr. Simplicis,	
Glycerini	āā gs. ℥ iv

Sig. A teaspoonful hourly, or each second hour, day and night, for a child from 2 to 10 years of age. Give no food or drink for thirty minutes after taking.

A suggestion made by Prof. Chas. H. Steele, of San Francisco, in regard to the tincture of iron, which I think is good, is as follows: "Contrary to the advice of the Pharmacopeia and Dispensatory, the tincture is usually, if not universally, dispensed when freshly made. It is not only an alcoholic solution of iron, but also a strong and comparatively irritating mixture of hydrochloric and nitric acids. After standing for one year, certain changes take place in the appearance and properties and chemical constituents of this tincture; it becomes darker in color and less transparent, and acquires a brownish tint and ethereal odor. It will no longer retain salts of quinine in solution, and it loses much of its styptic taste. Its acid elements have, to a great extent, disappeared, having combined with the alcohol to form a hydrochloric ether. It now responds to the physiological action of the nitrites, although in a milder degree, and is apparently not irritating, while the fresh tincture in large doses usually induces redness and coating of the tongue, and such irritation of the stomach that this important organ not only rejects medicine, but also food. The old tincture seems to allay irritation. Not only is there no vomiting (excepting, possibly, from the first taste of the medicine), but the tongue soon loses its coating and redness."

The iron should be continued every two hours until the membrane disappears; then you can lengthen the interval; but treatment should be kept up for a week or ten days, or longer, which would be determined by the condition of the patient. I neglected to say that at the beginning of the treatment I usually give a few small doses of calomel; after that, see that the bowels move at least once in 24 hours. A small dose of castor oil I find useful, as it is not irritating. Alcoholic stimulation plays an important part in the treatment in some of these cases, and should be given freely when called for.

The sick-room should be kept at an even temperature, 70° to 75° F. Daily sponging the body with alcohol and water will add much to the comfort of the little sufferer. Avoid all excitement, show as little anxiety as possible, as these little patients are close observers and are easily affected by what they see in those they have accustomed themselves to depend upon. Have regular hours for feeding; food should be given every two hours. Always bear in mind we have to deal with a disease that will tax the strength severely. Good, fresh milk is the best food, and will usually agree with these patients; about four ounces every two hours will be sufficient. Avoid as much as possible having the patient in the sitting posture. Keep in the recumbent position, as heart-failure is to be dreaded and should be guarded against.

There is one symptom for which you should be on the lookout, the first symptom of hoarseness or croupy cough. Treat at once, as you are sure to have trouble; discard your hand bulb atomizer, and use the steam atomizer with the alkaline mixture, and incorporate with the chloride of iron, or give separately, $\frac{1}{80}$ of a grain of bichloride of mercury every third or fourth hour.

To sum up, use your remedies vigorously for the first 48 hours, using watchful care, with gentleness and kindness, and you will get large returns for your trouble.

CHRONIC INDIGESTION.

By THOMAS L. MAHONEY, M.D., San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

In choosing the subject Chronic Indigestion I do so with the intention of bringing before this Society one which is of interest not only to the general practitioner, but also to the specialist, for who can expect to get gratifying results in a subject whose digestive tract is so impaired as to refuse to properly nourish the organism. We can see by a moment's reflection that the part affected must suffer from this general lack of nutrition.

Strictly speaking, chronic indigestion is any persistent, morbid condition of the alimentary canal that materially interferes with the reduction of a proper quality of food to that form in which it can be absorbed for the nourishment of the organism. Looking at the subject from this standpoint, however, indigestion is but the symptom of some pathological condition, so we must ascertain what the disease generally but incorrectly known as chronic indigestion really is.

In consulting the literature on the subject we again meet with an obstacle, from the fact that most of our standard authors treat two conditions, dyspepsia and indigestion, as identical; and in their articles on the symptomatology of this disease state as a remarkable fact that persons suffering from chronic indigestion or dyspepsia of years standing are very often well nourished. Here is where a distinction should be made, and dyspepsia should be considered separately from indigestion, for dyspepsia in reality is but the painful performance of a physiological act, whereas indigestion is the lack of performance. While a dyspeptic may be well nourished, because the process of digestion, though painful, is otherwise completely carried on, indigestion, on the other hand, must of necessity interfere with the nutrition of the body because the process is faulty.

During normal digestion changes occur in the gastric mucous membrane, which, if found in other mucous membranes, would be called catarrhal. The secretion of gastric juice is always accompanied by a considerable hyperemia, which is regularly followed by an abundant flow of mucus, and a considerable detachment of epithelium. When this physiological catarrh increases beyond normal bounds we have a pathological condition—acute gastric catarrh or acute indigestion. A succession of attacks rendering this condition persistent, produces chronic gastric catarrh, which is the disease erroneously known as chronic indigestion. This is a most troublesome condition for the physician to treat successfully, but with the recent advances in the examination of the stomach for disease, we are enabled to more correctly diagnose morbid conditions, and consequently to treat them more successfully.

Chronic gastric catarrh may be produced by a number of agencies, but in the majority of cases is caused by a succession of attacks of the acute trouble. These most frequently occur from the ingestion of food or nourishment, which, instead of undergoing the digestive process, remains in the stomach for hours acting as a foreign body, and causing first congestion and later inflammation.

In adults, outside of those addicted to alcoholic liquor, this trouble is not so frequently developed, because that which causes indigestion is generally eliminated from the diet. How, then, do we so frequently find this condition among adults? We know that once a mucous membrane is the seat of a chronic catarrhal condition it is most difficult to eradicate it, and that, if apparently cured, the condition seems prone to recur.

Infancy is the period when this most troublesome condition obtains a foothold. In this country especially, over one-half of the infants are artificially fed. It is not the artificial feeding that does the mischief, but its improper character. The infant's food is prepared so that every time it is fed large curds form, acting as foreign bodies. When we consider that the stomach is subject to these irritations from birth until the age when the child is able to take a mixed diet, we can readily see how an inveterate chronic catarrhal condition develops.

The symptoms that lead to a diagnosis of chronic gastric catarrh are anorexia, and a sensation of repletion on the ingestion of food. Subjective sensations in the region of the stomach are rarely absent, and in some cases are of a most peculiar character, bringing the patient into a condition of monomania. I remember treating a young man for chronic gastric catarrh. He remarked that some months previously, when drinking water, he had swallowed a lizard. His sensations confirmed this idea, and he was in a state bordering on melancholia. I remembered when a student having been directed to find a lizard for such a case, but without result. In the present case I therefore concluded to try a method that would dispense with the reptile. I informed the patient that I would give him a prescription for a mixture that would dissolve lizards. I was, therefore, much chagrined when the patient returned in a few days in a state of excitement saying that the lizard had dodged the mixture, and that it was dissolving his stomach.

Eructations are frequent and annoying, and nausea is also a constant symptom. In many instances this is succeeded by vomiting, the vomited matter consisting of undigested food, usually mixed with a large amount of mucus. The character of the vomit is an important symptom, as we see the excess of mucus that must be in the stomach from the quantity vomited. The reaction of this vomited matter is neutral if the vomiting occurs immediately after eating; if sometime after eating it is strongly acid, due, not to hydrochloric acid, but to the acetic, lactic, or fatty acids from abnormal fermentation. This acidity does not indicate that the gastric juice has peptonizing properties, for none of these acids have nearly the efficiency in promoting digestion possessed by hydrochloric acid.

Physical examination shows malnutrition, but not much that is distinctive of the disease.

Careful examination of the contents of the stomach, by recent methods, with the testing of the digestive power of the gastric juice, aid materially in diagnosis, which is made complete by the elimination of other diseases. The prognosis should be guarded as to a permanent cure, once the disease has been so established as to be chronic.

The patient is always in danger of death from intercurrent diseases. In an acute disease, he cannot be properly nourished, in spite of the fact that he can be properly fed. Medicinal agents administered through this diseased channel cannot be expected to do much good, as their absorption is prevented by the mucus present, and this is a factor that physicians often lose sight of in treating cases.

There is no doubt of the infectiousness of phthisis pulmonalis, and from the evidence we have at present there are few who will not admit the existence of the bacillus tuberculosis, and the fact that its inhalation produces phthisis. It is generally admitted that the germ will not live or propagate unless in favorable soil, and that soil is a depressed organism. I believe, in the majority of cases, this is brought about by malnutrition, the result of a diseased digestive tract. The mortality from this most frightful malady, which is responsible for such a large percentage of deaths, would be greatly reduced if the public could be taught how to properly nourish the child in the first year of its existence, and not force on the helpless being a diet which, instead of properly nourishing, produces chronic gastric catarrh. I am led to this conclusion regarding phthisis from the fact that those nations who have been subjected to hardships as regards food, are most prone to have a large percentage of phthisis.

It will be seen that treatment, in the main, should be devoted to prevention, but in those cases that have already developed, a great deal can be done to help the nutrition of the organism. By correcting errors in diet, making a study of the victim's idiosyncrasies regarding food, and above all things, not sending such patients away with the injunction, "be careful what you eat," but get their coöperation in selecting those forms of nourishment which seem to be the most easily tolerated, much may be accomplished.

A great deal can be done with medicinal agents that tend to improve digestion, such as artificially supplying hydrochloric acid where examination of the contents of the stomach shows diminution of the hydrochloric acid. Pepsin does good when administered in conjunction with the acid. The alkalies are of benefit in alleviating the annoying symptoms caused by hyperacidity, the result of the acids of abnormal fermentation. Creasote is of great benefit in preventing abnormal fermentation, but the method which seems to give the happiest results, is systematic lavage of the stomach.

1903 Polk street.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D , Sacramento, Cal., and
HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Thiol in the Treatment of Female Diseases.—GOTTSCHALK, after using thiol for 9 months, believes it to be as efficacious as ichthyol in the treatment of female diseases, while its freedom from odor is a positive advantage. He first employed thiol in the treatment of parametritic and perimetritic exudations. He introduced tampons saturated in a solution of thiol in glycerine (10 to 20 per cent.) into the vagina, renewing every day or every other day. At the same time he applied to the abdominal wall a thiol salve of the same strength. The tampon causes a sensation of abdominal constriction, accompanied by an abundant vaginal secretion, which ceases upon the removal of the tampon. Thiol applied to the skin produces effects similar to those of iodine, and after daily applications of the salve for six or eight days, it is necessary to wait a few days before continuing its use. Gottschalk has seen extensive pelvic exudations disappear in a few weeks under the influence of this local treatment supported by the internal administration of thiol. In recent and chronic forms of endometritis he introduces into the uterine cavity, by means of a Playfair sound, small cotton tampons saturated in pure liquid thiol. These topical applications are painless and inoffensive. They do not excite uterine colic or perimetric inflammation, even when removed every two or three days. They are, however, sometimes followed by a slight hemorrhage. He uses powdered thiol in cervical erosions with the best results. The only objection to this remedy is its comparatively high price.—*Centralblatt f. Gynaekologie—Gazette de Gynécologie*, March 15, 1894.

Puerperal Insanity.—Properly speaking, the puerperal condition refers only to the functional and organic modifications which take place in women during and after parturition, before the return of the menses, or the physiological establishment of lactation. But from the point of view of puerperal insanity, this condition may be divided into the periods of (1) Gestation. (2) Puerperal condition proper. (3) Lactation. The following statistics show the relative frequency of psychosis in each of these periods: Gestation, 3.1 in 100; puerperal condition proper, 9.2 in 100; lactation, 3.6 in 100. According to MARCÉ, insanity caused by pregnancy generally develops about the end of the fourth month, and increases progressively. Melancholia is the most frequent form. SCHMIDT gives the following proportions: 52.9 in 100, melancholia; 31.3 in 100, mania; 10.3 in 100, delirium syst. chron.; 5.8 in 100, gen. par. Marcé finds that labor seldom relieves this form of mental disease; on the contrary, the symptoms are generally aggravated, and melancholia often assumes the form of more or less violent mania. Abortion, sometimes recommended as a curative measure, should be strictly forbidden. Gestation, with these patients, is usually normal, and abortion seldom occurs spontaneously. The opinion advanced by some authors that pregnancy exerts a beneficial influence upon insanity already established, is not sustained by statistics. ESQUIROL believes that marriage and labor usually stimulate the disease. When psychosis appears at an early period, prognosis is more favorable than when it occurs toward the end of gestation, but it generally persists for several months, and relapses may be expected in subsequent pregnancies. The causes of puerperal insanity proper—that is, insanity—which developes during the period following labor before the organs of generation have resumed their normal functions, are divided by Campbell-Clark into predisposing causes and producing causes. In the first category, hereditary predisposition is the most important, as it exists in 56 per cent. of these cases. The complicated influences affecting a first pregnancy are next in order. Nearly half the patients suffering from this form of psychosis are primiparæ. Among producing causes infection occupies the first rank—infection of the uterus or of other organs. Campbell-Clark reports 70 to 100 cases caused by infection, 66 by infection of the uterus, and 4 of the kidneys. More than half these patients were under the influence of intense moral emotions; and we realize the importance of this influence when we consider the large number of women who suffer from puerperal infection. Dr. IDANOF gives the proportion as 8 or 9 per cent., and the comparative rarity of puerperal insanity. The disease usually appears about the fourth or fifth day. Irritability, headache, insomnia, agitation, diminished secretion of milk, are premonitory symptoms. Fever may or may not be present, but the head is always hot. Sometimes the disease assumes a fatal form, when the tongue becomes dry and fuliginous, the secretions cease abruptly, and the patient falls into a comatose state, which soon ends in death, Puerperal insanity proper assumes the most diverse forms, mania in 47.8 per cent.; melancholia in 37.9; systematized delirium in 5.8; acute dementia in 5.5 Prognosis is favorable in most cases, more favorable in mania than in melancholia. Patients suffering from insanity after prolonged lactation usually present symptoms of extreme exhaustion. Prognosis is not unfavorable, but more grave than in puerperal insanity proper. Therapeutic indications are the same in all kinds of puerperal insanity. Treatment consists in the removal of all exciting causes—a tonic *regime*, mild purgatives, injections of hydrate of chloral, and other measures likely to exert a soothing influence upon the mind.—*Progrès Médical*, April 7, 1894.

Conservative Ovarian Operations.—POZZI performs ignipuncture and partial resection of the ovaries in cases of diffused ovaritis, and of sclero-cystic degeneration. If a very small part of the ovarian tissue remains intact the function of the organ may be preserved. Limited intervention, however, is useless in purulent cysts or agglomerated follicular cysts. *Operative technique.*—After catheterization, and the usual antiseptic precautions, make a small incision (5 to 6 cm. in length) low down in the linea alba. Introduce an aseptic compress for the purpose of pushing up and covering the lower intestines; if a second compress is necessary place it beside the first, and attach forceps to the ends of both. If a table with inclined top is not available, two assistants should raise the lower extremities and the pelvis so that the annexes may be readily found. They should be loosened from adhesions, drawn through the opening and surrounded by an aseptic compress, so that the operation can be performed outside the abdominal cavity. The permeability of the tubes can be ascertained by passing through them a stilet, which should reach the uterine horn. If the tubes are open there is sufficient reason for attempting to save a part of the ovaries, and further proceedings depend upon the condition of these organs. If they are large, soft, whitish, manifestly infiltrated, pierce the edematous ovarian stroma with the redhot point of the thermo-cautery as many times as the size of the ovary and its degree of edema indicate; if small cysts are scattered over the surface, open them with the thermo-cautery, and carefully burn their inner surfaces. Redhot ignipuncture is hemostatic, but if slight hemorrhage should occur, one or two points of catgut quickly assure hemostasis. The cauterized ovaries may now be replaced in the pelvis. When the uterus is retroflexed hysteropexy should be performed. If, notwithstanding all precautions, there seems to be danger of hemorrhage, apply a small Mickulicz drain by means of two bands of iodoform gauze, which, protruding from the wound, assure drainage, and assist hystero-fixation. The abdomen should be closed by three series of sutures, of which two are of catgut. The last superficial series may be united by intradermic suture, which leaves no outward traces. After-treatment is simple. A slight rise in temperature may be expected on the third or fourth day. While ignipuncture is applicable in diffuse ovaritis, partial resection of the ovary is indicated in sclero-cystic ovaritis. After ascertaining the permeability of the tubes as before, the diseased part of the ovary may be removed, and the edges of the remaining portion carefully sutured with catgut. The cases most favorable to partial resection are those in which the disease is limited to one part of the ovary—for example, cases of large serous or sanguineous follicular cysts. When small cysts are scattered over the surface, resection is indicated whenever dissemination is not generalized. The cysts are usually confined to the free border of the ovary, or are scattered over the convexity of the organ in the form of small transparent bluish points, while there is a zone of unaltered tissue in the vicinity of the hilum. Dermoid cysts, and the thin layer of ovarian tissue upon which they rest, should be removed, and the edges of the wound carefully sutured with catgut. After resection of the ovary, Pozzi secures salpingopexy by means of a few points of catgut which unite the tube to the remainder of the ovary, and he then completes the operation in the usual manner.—*Gazette de Gynécologie*, March 14, 1894.

SURGERY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and

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Aniline Products in the Treatment of Carcinoma.—MEYER (*Annals of Surgery*), summarizes his opinion of this method of treatment as follows: "The use of the aniline dyes in the treatment of inoperable carcinoma (malignant growths generally) is 'a palliative treatment,' not a cure. In very rare cases this treatment may cure. Carcinoma and sarcoma of hard type (especially sarcoma) are more influenced than soft ones; those of the soft tissues more than of the bones: those with a scanty blood-supply more favorably than rapidly growing neoplasms with abundant circulation. The disseminated cancer is not suitable for the aniline treatment. The treatment by parenchymatous injections requires a perfect knowledge and application of the principles of aseptic and antiseptic surgery." The treatment is suitable only for inoperable cases, and should never be tried where an operation is possible. It is tedious and time-robbing—the necessary precautions of antisepsis make it so—and also expensive, so that it is suitable for the rich only, outside of hospital practice. The treatment will require a continuous attendance for many weeks or months. The method of treatment is as follows: "A very handy shape of the pure drug is the pyoktanin (ceruleum or blue) pencil. If dipped in water and then rubbed on the surface of a sore, ordinary cancerous or sarcomatous, it easily makes a crust, a dry eschar, under which cicatrization often rapidly goes on. The standard solution for parenchymatous injection is 1:500. It forms no sediment if filtered through asbestos. The solution is to be kept in a dark bottle with glass or rubber stopper. Only a small quantity—about an ounce—should be prepared at the time; it is still better to prepare it fresh for each injection. For external application in moist dressings a higher percentage can be applied." The *technique* in general consists of antisepsis in instruments, hands, and skin. The needles should be kept in alcohol, and boiled after each using. "The syringe is an ordinary well-working aspirator which holds two drachms. Before and after using it is washed inside and outside with a 5 per cent. carbolic solution. It shall be used only for this purpose. The amount of solution varies from one-half to three drachms, according to the size of the growth. The spot where the needle entered is compressed after the withdrawal of the needle with a ball of moist antiseptic cotton until all oozing has ceased. It is then rubbed with ether and covered by a small piece of antiseptic gauze, fastened by pyoktanin, or iodoform, or ordinary collodium. Any other dressing is superfluous. It is wise in the beginning of the treatment to distribute the dye throughout the entire tumor as rapidly as possible. The injections are, therefore, better made every other day; later, every third day regularly." The effects produced are: (1) The analgesic; this is most important and marked. (2) The improvement of function in the part involved. (3) The general condition is unmistakably changed for the better. No dangerous symptoms have ever been seen, although occasionally there are present annoying symptoms. "In no case did the injections ever prove really harmful to the patient." A general local improvement is seen in the growth, accompanied with edema sometimes; this, however, is never serious, and disappears on massage. Breaking down of the injected tissue is sometimes seen, and a number of sinuses may form, or may unite to form a cavity, that, if punctured and treated antiseptically, heals quickly. In general, the effects of this method of treatment are favorable, and the author believes there have been cases cured, though it is a palliative rather than a curative treatment, and produces best results as such.—*American Journal of Medical Sciences*, May, 1894.

Bier's Treatment of Articular Tuberculosis.—MIKULICZ (*Centralbl. f. Chir.*), reports at some length on Bier's method of treating articular tuberculosis in the limbs by artificially produced congestion and hyperemia. It is now too early, he states, to give a decided opinion on the value and prospects of this plan, but there can be no doubt, it is held, that in some cases it has proved very effectual. A case is here recorded of white swelling of the knee, previously treated without success by injections of iodoform, in which, on the application of Bier's treatment, the tuberculous deposits disappeared in the course of eight weeks, the joint being freed from pain and active disease, but remaining much impaired in consequence of partial destruction and subsequent cicatrization of the ligamentous structures. Three other cases, in two of which iodoform was not used, are referred to in which this method of treatment had very good results. In a fifth case—one of caries of the tarsus—although the progress of the tuberculous disease was arrested by Bier's treatment, it was found necessary to remove the foot, as much of its osseous structure had been destroyed by the disease. In three other cases the treatment did neither good nor harm. In his comments on these clinical reports the author states that the prospects of curing articular tuberculosis by any means short of radical removal depend on the intensity of the reaction of the diseased structures. In some subjects the reaction is so active as to be capable of effecting cure without any therapeutical aid from without, whilst in other subjects there is so little resistance in the affected structures that any method of conservative treatment hitherto devised will be found quite useless. There can be no doubt, Mikulicz holds, that Bier's method aids and promotes this process of reaction in many cases in which, without such aid, such reaction would fail in its struggle with the tubercle bacillus. It still remains to be proved whether the good results of the method are to be attributed to simple hyperemia, to the curative action of effused serum, or to a form of self-developed tuberculin action. In his practice Mikulcz varies the details of the treatment in different cases, adapting the strength and duration of the means of producing congestive hyperemia to the amount of local reaction and to the tolerance of the patient. It is held to be advisable in most cases at first to apply the bandage lightly and to allow it to remain on the limb for only a few hours at a time. The treatment should be carefully and frequently supervised, particularly when the patient is very tolerant of the bandage and can wear it day and night without suffering pain or uneasiness. If the bandage be retained for a long period it is apt to cause muscular atrophy of the limb at and below the seat of constriction. The best indication of a beneficial working of Bier's method is cessation of pain in the diseased joint. MILLER (*Edin. Med. Jour.*) reports favorably of Bier's congestion treatment of tuberculous affections of the extremities. This method consists in placing a broad elastic band round the affected limb, a few inches above the diseased part, firmly enough to produce venous congestion. Bier recommends that this congestion should be kept up continuously and that the patient should be permitted to use the limb. The elastic band should be broad and a layer of lint or wool should be placed under it to protect the skin. The distal portion of the limb is supported by a bandage up to the affected part, so that the congested area is limited to the immediate neighborhood of the disease. Miller states that this method is a useful one, and deserves further trial. He prefers intermittent to continuous compression, as the former method is attended with less risk and is followed by equally good, if not better, results. It is now employed as part of his routine treatment for mild cases of strumous joint disease and skin affections of the extremities. The improvement effected by this treatment was more marked and striking in cases of skin disease than in those of joint disease, but the author acknowledges that in the latter class of cases the joints seemed to improve faster than they would have done had they been treated by mere rest. In regard to the joint affections, however, a full and extended trial of Bier's method was hindered by the pressure of time and want of accommodation in the author's wards.—*British Medical Journal*, April 21, 1894.

A Simple Apparatus for the Sterilization of Catheters.—FRANK describes (*Annales des Maladies des Organes Génito-urinaries*) his apparatus for the sterilization of urethral catheters and similar instruments. A sterilizer of suitable size is used. In one end is adapted an upright reservoir, to be filled with water, or, better, 1 per cent. solution of potassium. From the top of this project horizontally several conical tubes to which the catheters are attached. Rubber tubing may be used to make the connections more perfect. The instruments are sterilized externally in the usual manner by the steam from the sterilizer, while the inner surface is made sterile by the jet of steam which passes through from the reservoir described. The reservoir is heated by the liquid in the sterilizer. Frank has infected old and rough rubber and silk catheters with urine from cases of cystitis, and, in addition, pure cultures of the bacterium coli commune, and of charbon, and from these tube cultures were made, which showed abundant growths at the end of three days. After sterilizing ten minutes, tubes were again inoculated, but they remained sterile.—*American Journal of Medical Sciences*, May, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

Complications of Cataract Extraction and Subsequent Healing.—DRS. DE SCHWEINITZ, JACKSON, and RISLEY, in lectures on the above topic, expressed their views as being opposed to syringing the anterior chamber with antiseptic solutions, with the exception of boracic acid in 3 per cent. solutions. In case cortical substance remains in the anterior chamber it may be removed by washing it out with an aseptic solution. A boiled solution of salt, one-half per cent., at a temperature between 99° and 105° F. is to be preferred for this purpose. A stream of this solution injected against the partially prolapsed iris is often a gentle and efficient means of restoring a round pupil. Dr. de Schweinitz mentioned, among accidents which might occur during cataract extraction, the introduction of the knife with the cutting edge in the wrong direction, the falling of the iris before the edge of the knife, too small an incision, dislocation of the lens and escape of vitreous. In case the knife has been introduced wrong, it should be withdrawn and the operation postponed. If the incision is too small, it can be enlarged with a blunt pointed scissors. A dislocated lens should be extracted with a loop. When vitreous has escaped, pressure should be promptly removed, and the lens, if not already out, should be quickly extracted, and the eye closed with as little manipulation as possible. During healing severe pain would indicate intraocular hemorrhage, suppuration of the wound, prolapse of iris or iritis. Iritis is likely to come on from the fifth to the tenth day. It might arise from one of several causes, imperfect toilet of the wound, too early exposure to light, or a mild septic process. Suppuration of the wound has been very much reduced by modern methods. When it does occur the treatment is hot compresses, antiseptic irrigation, and cauterization of the wound, and, according to Darier, subconjunctival injections of bichloride of mercury. In most cases of extraction, some improvement can be made in the result by doing a secondary operation upon the capsule. This should be done within two months from the primary operation, and is very slight.—*Ophthalmic Record*, May, 1894.

Rhinitis Fetida, with Aural Disease and Hypertrophy of Uncinate Process and Mucous Membrane covering it, Simulating So-called Cleavage.—Dr. Wm. Hall reports the case of a lady, age 45. She had had fetid rhinitis for five or more years, and and been treated by removal of the crusts, antiseptic sprays and douches, galvano-cautery, trichloractic acid, iodol ointment, etc. In January of this year an attempt was made to drain the antrum through a tooth socket. A considerable quantity of pus escaped through the opening. The antrum had been syringed until within the last week, when the operation became too painful. Rhinoscopic appearance: In the right nostril could be seen the condition corresponding to the description of "cleavage" of the middle turbinated body. The body on the outer side of the cleft in this case was clearly a pathological enlargement of the uncinate process of the ethmoid, together with the mucous membrane covering it. The cleft was choked with granulations, and it was inferred that the antrum contained granulations, or polpi, or some other diseased condition of the mucous membrane. Further treatment proposed: (1) Removal of the hypertrophied area (uncinate body). (2) Opening of the maxillary antrum through the canine fossa. (3) Establishing an accessory opening between nose and antrum, either in middle or inferior meatus.—*Medical Press and Circular*, May 7, 1894.

Oxycyanide of Mercury as an Antiseptic in Ophthalmology.—Oxycyanide of mercury ($Hg OHg (CN) 2$) has been studied by Dr. Schlosser as to its relative antiseptic and irritating properties, as compared to bichloride of mercury. It has about equal power as a bactericide as bichloride of mercury, but is only one-fourth as irritating, locally, as the latter agent. It can, therefore, be used four times as strong as the sublimate without injurious effect upon the tissues. It has also the further advantage of having much less power to coagulate albumin. It does not possess the serious objectionable feature of bichloride of injuring the instruments. Instruments can be sterilized by laying them in solutions of oxycyanide of mercury without the edges being injured. The author has had good results in conjunctival catarrh by applying a one to two per cent. solution to the everted lids. Generally the unpleasant subjective symptoms disappear by the following day. The pain produced by the application passes away in fifteen minutes. In case it is desirable, a few drops of cocain solution can be used to allay the pain. In dacryocystitis and in dacryocysto-blennorrhea it has been followed by excellent results in his hands. He washes out the lachrymal sac with a one per cent. solution. One treatment usually cures the case. Among thirty-seven cases treated by this means none required more than three applications to effect a cure.—*Transactions Heidelberg Opthal. Gesellschaft*, 1893.

Indications for Extirpation of the Lachrymal Sac.—Dr. L. Muller gives seven indications for extirpating the lachrymal sac, as follows: (1) In cases of disease of the lachrymal sac in which the patient is unable to undergo treatment with Bowman's probes. (2) In case the nasal duct is obliterated, as happens in lupus of the nose. (3) When the lachrymal sac is unusually thick and that it cannot be hoped to be reduced. (4) In case tuberculosis of the sac is suspected. (5) In cases of necrosis or syphilitic disease in the neighborhood of the sac. (6) Generally when blenorrhea of the sac is complicated with corneal abscess or a mature cataract. (7) In case of excessive ectasia and thin-walled sac.—*Klinische Monatsblätter f. Augenheilkunde.*

A Case of Severe Blepharospasms, with Recovery.—Dr. H. Merz gives the history of a tailor, 41 years old, who had been suffering for two years with blepharospasms to such a degree as to incapacitate him for work. He was suffering also from slight conjunctival catarrh. The patient had undergone a variety of treatments without benefit. Among these were application of the eye douche, washing the eye out with sublimate solutions, lead lotions, electricity, and several other remedies. Finally, injections of strychnine were given in the supraorbital region. The injections were made daily in gradually increasing doses. The condition of spasms was entirely cured in about three weeks, and with the improvement also came great improvement in the patient's general health.—*Klin. Monatsblätter f. Augenheilkunde.*

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. Simmons, Jr., M.D., Sacramento, Cal.

Posterior Urethritis.—Dr. F. Tilden Brown, in a paper with this title, says: Acute posterior urethritis is rather a complication than a sequence of anterior urethritis. Some think that the auto-infective agent of gonorrhea is conveyed from the anterior to the posterior urethra, and other portions by means of the lymph channels. Most observers, however, are inclined to believe that the disease traverses to the posterior urethra by continuity. At any rate, between the 16th and 26th day, an extension generally takes place to the posterior urethra. When the bulbous urethra is filled with pus there may be pressure upon it, by the clothes or otherwise, which favors its continuance. Locomotive engineers, tailors, oarsmen and bicyclists seem particularly prone to this complication. The paucity of glands, lacunæ and follicles in the posterior urethra, as compared with the anterior urethra, seems to offer the best explanation of its frequently escaping infection. He had seen several cases in which the fluid has passed into the bladder during irrigation of the urethra with a Kiefer nozzle. Spontaneous extension of an anterior urethritis to the posterior urethra may be expected in a debilitated person. The subjective symptoms may be at first wanting, and hence the condition may for a time be overlooked, and may not be discovered until after the patient again indulges in sexual intercourse, when the sudden reappearance of the discharge may lead him to think that he has suffered a new infection. There is, however, more commonly a sudden development of dysuria and disturbance of the sexual apparatus. Tenesmus is the all-important symptom in posterior urethritis, and there will be urgent demand to urinate, which, if not immediately attended to, will lead to a dribbling of the urine. Spermatozoa may be present with undue frequency in the urine, and lead to a suspicion of the existence of a posterior urethritis. In acute posterior urethritis, instrumental examination is contraindicated. By rectal examination by the finger, it will be found that pressure upon the prostate gland will cause pain and tenesmus. When the affection is severe there may be marked constitutional symptoms. Unless the disease be carefully and systematically treated, there will be frequent relapses. In the treatment the tenesmus must first be relieved by the use of suppositories or deep injections of cocaine or morphin. The urine should be rendered nearly neutral, using the benzoate of ammonia when the urine is alkaline, or the bitartrate of potash when the urine is acid. Sandal-wood or salol may be administered internally. After the subsidence of the acute symptoms, deep urethral injections of very weak solutions of nitrate of silver may be employed. In chronic posterior urethritis the amount of disturbance is quite variable. In what proportion of cases the gonococci cease to exist is not known, but all such cases should be looked upon as suspicious. To determine whether or not a case is still capable of carrying infection, it may be necessary to produce an exacerbation of the disease by the introduction of an irritating solution, for it is well known that gonococci are much more numerous during such an exacerbation. The subjective symptoms are similar to those of the acute form, except that tenesmus is usually absent. The existence of the "comma" thread in the second urine glass is strongly suggestive of chronic disease of the posterior urethra, if disease of the anterior urethra can be excluded. If disease of the anterior urethra cannot be excluded, this portion of the canal should be thoroughly irrigated, then the first passage of urine would indicate the condition of the posterior urethra. Deep pressure over the membranous urethra and perineum is more likely to show tenderness than digital examination of the rectum. Here the urethoscope is exceedingly valuable. At the first examination the lesion is exposed, and a 3-per-cent. solution of nitrate of silver applied by means of a specially devised syringe with a cotton tip. This treatment should usually be repeated after two or three days. When the submucous layers are infiltrated, absorption will be promoted and better results obtained by the use of iodine.—*Journal Cutaneous and Genito-urinary Diseases*, May, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By Wm. Watt Kerr, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Tracheal Irrigations in the Treatment of Croup.—After giving the details of a successfully treated case of croup by the method of tracheal irrigations, the child being placed in an inclined position, Guelpa (*Journ. de Médecine de Paris*) draws the following conclusions: (1) Tracheal irrigations, while the child lies with the head lower than the feet, are not only destitute of danger, but are also well borne and easy of application. (In the case described by the author the irrigations were practised by the father of the little patient, with the aid of the servant.) (2) The constant inclined position of the patient in bed facilitates the expulsion of bronchial mucosites, and is a very practical measure, of great value in the treatment of croup in all the stages of the disease. (3) Abundant irrigations exercise a beneficial influence also in diphtheritic manifestations of the throat and nose; therefore they ought likewise to be practised in cases of diphtheria of the larynx and trachea. (4) Finally, the case that has been described seems to show that, with reference to the etiology and treatment of concomitant or late thoracic lesions of croup, these cannot be looked upon as direct or indirect consequences of respiratory infection, but that the condition of the digestive organs must be considered also; indeed, the case shows that the infection of the bronchi and pleura was of an intestinal origin.—*Therapeutic Gazette*, April, 1894.

Salol in Phthisis.—Lutz refers to the frequent failures of new remedies for the treatment of phthisis, and proceeds to describe a method he has employed successfully for more than two years. It consists in giving the patient about 1½ drachms of salol daily, the single dose being about 20 to 30 grains, but latterly it has been found that 6 or 7 grains sometimes suffice to give similar results. The drug is best adapted to cases of phthisis florida, and is contraindicated where renal complications exist. Cases with high fever and much expectoration at first show no amelioration; later, however, pyrexia and night-sweats disappear totally. The sputum becomes less, the cough diminishes, but the number of bacilli remains unchanged. Salol appears to lessen disintegration of tuberculous material, but has not any anti-tubercular action.—*British Medical Journal.*

Intravenous Injections of Sublimate Solution.—G. BACCELLI, after making numerous experiments on animals, has established the method of intravenous sublimate injections in treating obstinate, malignant malaria, cerebral syphilis and hydatids of the liver. The solution used is—

℞. Hydrarg. Perchlor. .... gm.i.
Nat. Chlorat. .... gm.iii.
Aqu. Distil. .... gm.1000 M.

By pressure, the veins at the elbow are made to stand out, and a syringeful (1 c.cm.) of the fluid is injected, which is followed by some salivation in about five or six minutes. This amount is injected daily, and soon it is gradually increased up to 8 c.cm. The advantages of the method are: (1) The small quantity of the drug used. (2) The possibility of combating rapidly the severe symptoms due to syphilitic blood poisoning. (3) The prompt action on the vessel wall, the favorite seat of syphilis. The author speaks highly of the treatment of hydatid of the liver by injecting 20 grammes of a 1:1000 sublimate solution after about 30 c.cm. hydatid fluid has been drawn off. After five days the patient may be looked upon as cured, since the parasite is dead, and the symptoms rapidly recede.—*British Medical Journal*, April 7, 1894.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

The Organic Juices.—WILLIAM C. KRAUSS specifies the epoch in which we live as the sky-rocket period of the 19th century. Men, like methods, approach their zenith with an increasing roar and sparkling brilliancy, and as suddenly fade, to fall with a dull and heavy thud. The first reports of the method of Brown-Sequard read like a fairy tale, and the "Elixir of Life," so-called, seemed to be the magic fluid that philosophers had vainly sought for centuries. Brown-Sequard resuscitated a method of treatment dormant for more than 300 years in the alcoves of the National Library of Paris, and established by one Dr. Mizauld, a physician who lived in Paris in the 16th century. The writer makes the following quotation from the work of Dr. Mizauld: "If the genital organs of a red bull be bruised in a mortar and taken by a woman in some wine or soup, it will give her a disgust for love, while, to the contrary, the same beverage taken by a debilitated man will reawaken his amorous desires." The famous communication of Brown-Sequard to the Sociétè de Biologie of Paris, on June 1, 1889, certainly contained nothing more explicit. Many enthusiastic reports were presented in 1889 and 1890, confirming Brown-Sequard's observations after injections of testicular juice. Gradually the reports became less numerous and less encouraging, save those which came from the master himself and some of his former pupils. Perhaps the greatest check to this movement was the fact that Charcot and his pupils refrained from using these injections, or, at least, never gave it their sanction. Pulawski made a series of experiments with 12 cases, and came to the following conclusions: "Local pain and abscess formation; fever with chills; no specific action; subjective and positive amelioration were dependent upon suggestion." Ovarian juice has given, according to Brown-Sequard, similar results, though less marked than those of testicular fluid. Spermin is a derivative of Brown-Sequard's testicular juice, and its action seems to be similar. Brown-Sequard's method is discontinued at the present time by neurologists, both in America and in Europe, but the master and his pupils still employ it with good results in a certain class of nervous diseases. Following this method of treatment, Gley injected the juice of thyroid glands in dogs deprived of these organs, and found, instead of dying, they recovered without serious difficulties. In the human family, it has been found, after removal of the thyroid gland through disease, that a certain train of symptoms will develop, which have received the name of myxedema, an affection manifested by swelling of the face, body and extremities, loss of hair, subnormal temperature, etc. Horsley attempted to transplant the thyroid gland of animals to these patients, and met with particularsuccess. Murray, of Newcastle, then injected hypodermically a glycerine extract, with good results. The injections were followed, in many cases, by pain, inflammation and abscess formation. To overcome these hindrances, Fox and Mackenzie advised treatment of myxedema by feeding with sheep's thyroid, and the results seem to be every way satisfactory. Dieulafoy has injected extracts of the cortical portion of the kidney into patients suffering with Bright's disease. He proposed the name nephrine for this particular fluid. Comby and Dieulafoy have also injected an extract of pancreas in cases of diabetes, with temporary good results. The author's conclusions in regard to the animal extracts are: "That since recent experimenters fail to corroborate the results obtained immediately after the introduction of Brown-Sequard's method, the whole matter must be left open for further investigation. That many of the results obtained were due to suggestion and auto-suggestion, and that no specific action has been discovered." In a recent work by Chèron, of Paris, the following occurs: "All liquids when introduced under the skin produce identical effects, provided they are not toxic and have no specific toxic action. They increase arterial tension, and, in the diseases in which these fluids have been used, a degree of hypertension has existed, which being relieved by injections, temporary results have followed."—*The Medical Age.*

Embolism of the Brain.—SAVELIEW has studied all the cases of this affection—102 in number—which have occurred during the 37 years (1856 to 1893) of Virchow's *regime* in Berlin. The majority of patients are afflicted with some heart lesion in more than 89 per cent. of the cases. The main source of cerebral emboli is from precipitates from the blood on the endocardium, and next in order of frequency ulceration processes in the endocardium itself. The distribution of 144 clinical cases of cerebral embolism according to age was as follows: (1) 1 to 10 years, 4; (2) 11 to 20, 17; (3) 21 to 30, 33; (4) 31 to 40, 23; (5) 41 to 50, 35; (6) 51 to 60, 26; (7) over 60 years of age, 6 cases. According to the foregoing, the largest number of cases of cerebral embolism occurred during the fifth decennium. The writer found cerebral embolism of more frequent occurrence in women than in men. The clinical course of the affection is briefly as follows: The individual is usually attacked suddenly without warning. There may be fever, chills, delirium, vertigo, headache, vomiting, palpitation of the heart, dyspnea, together with motor sensory disturbances. After an attack the patient may improve greatly; consciousness is restored, paralyses and other manifestations may disappear. Improvement is of course dependent on the reëstablishment of the circulation of the blood by the collateral vessels. It is also dependent on the fact that certain parts of the healthy brain can do vicarious duty for the affected parts. Sooner or later a second attack occurs, and the source of the emboli cannot be eliminated. The following are cited as characteristic symptoms of embolism: Loss of consciousness, demonstration of etiological factor (heart lesion), absence of prodromata, temporary character of the paralyses and aphasia. It must also be noted that embolism is more frequent on the left side, and attacks women more often than men.—*Virchow's Archives*, January 10, 1894.

Infectious Icterus.—This affection, also known as icterus febrilis (Weil) and morbus Weilii, has been carefully studied by MUNZER, who reports observations made on nine patients. The latter presented themselves usually with high fever; the fever begins suddenly with chills. The highest point of the fever is attained on the third or fifth day of the sickness, falling by crisis or lysis. With the subsidence of the fever the patient becomes convalescent. Icterus occurs on the third or fifth day, or it may be postponed until the temperature falls to the normal. The intensity of the icterus is rapid and is probably due to resorption. The liver is usually enlarged and painful on pressure. Enlargment of the spleen is constant. The severest manifestations of the disease arise from renal complications. In all the cases albuminuria was present. Usually the quantity of urine is diminished, even to anuria, while in other cases uremia occurs. In the sediment of the urine casts and renal epithelium can be demonstrated. Among the other symptoms were: Muscular pains, epistaxis and cutaneous hemorrhages. The following conclusions were formulated: (1) Infectious icterus is a sufficiently characterized general infectious disease, which is manifested by fever, nephritis and icterus. It occurs during the summer months (May-August) and attacks young people, especially males. (2) The course of the disease varies, and the prognosis is always uncertain. (3) The cause of the icterus is not known.—*Centralblatt f. Klin. Medicin.*

A New Method of Auscultatory Percussion.—DR. ANDREW H. SMITH recommends the following method of auscultation in detecting shades of differential dulness not easily determined by ordinary methods. The binaural stethoscope fitted with the small extremity intended for examination of the heart is held between the patient's teeth and the lips are closed around it. During the percussion the nostrils are compressed with the fingers. By this method, there is a confined column of air reaching uninterruptedly from the interior of the patient's lungs to the tympanum of the examiner's ear; thus, impulses communicated to this column are completely shut in and none of the sound waves are lost. The length of the sound waves will be in proportion to the elasticity of solid structures acted upon by the percussing finger. If there is no solid tissue beneath to dampen the vibrations of the thoracic wall, the waves will be long, the pitch low, and the tone resonant. The effect of this form of auscultation does not differ in kind from that obtained in ordinary percussion, but its intensity is much greater., In examing the back of the chest, a stethoscope with long tubes is necessary, or the percussion may be made by an assistant.—*Medical Record.*

Protozoa and Carcinoma.—I. ADLER, after critical survey of the literature that has accumulated during the last few years on protozoa and their relations to malignant tumors, concludes as follows: "The existence of parasitic protozoa in cancer is probable, though the greater part of what has hitherto been described as parasitic is certainly not so. No constant nor in any way specific organism has as yet been demonstrated beyond possibilities of doubt. At present no facts, histological or otherwise, compel the assumption of a parasitic origin of carcinoma, while there are very strong and valid arguments against such assumption."—*American Journal of Medical Sciences.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M.D., Assistant Physician, State Asylum for Insane,
Stockton, Cal.

The Hypnotic Action of Somnal.—Dr. Giovanno Memom reports that he has obtained good results from the administration of somnal, in such forms of insanity as epileptic frenzy, paranoia, alcoholic psychose-mania, etc. He thinks it is superior to chloral, sulfonal, and trional in many cases, not only in its hypnotic effect, but it is better tolerated and is not followed by any disagreeable after-effects. The writer does not agree with Umphenbach, who reported unfavorably as to the effect of somnal on insane women, and claims that it has the same effect, provided special precautions are taken, in insane women as in men. It is very beneficial in the insomnia of hysteria of tuberculosis, and in those patients suffering with cardiac affections, in whom it is not contraindicated as some of the other hypnotics, because of the unfavorable sequelæ. In various cases where the other hypnotics, as chloral, sulfonal, and morphin, have not given lasting and satisfactory results, somnal has succeeded without provoking any disturbance or secondary phenomena. According to Myers, somnal should have a good effect in convulsive cough, spasmodic laryngitis, asthma, and chorea. Dr. Memom has given somnal in 3 to 5 gramme doses, and has succeeded in obtaining a sound sleep of from five to six hours' duration. It is not followed by any deleterious effects, either on the part of the digestive, respiratory, or circulatory systems.—*Bull. de la Reale Acad. di Roma.—Journal Nervous and Mental Diseases.*

Sulfonal in the Treatment of the Insane.—Dr. J. H. Scally, of the Maryland Hospital for the Insane, reports favorably concerning the action of sulfonal in the stages of excitement during attacks of acute mania, mania following epilepsy, recurrent mania, chronic mania, and also in melancholia. The writer does not give it regularly every day, but only when extreme restlessness and motor excitability are present. In cases of acute mania just admitted, when it is necessary to secure immediate rest, sulfonal has not failed to give the desired effect. In such cases it was given in drachm doses, preferably in whisky, and generally produced from six to eight hours of sound sleep, and the patient would, after waking, be fairly quiet for from eight to twelve hours. In each case sleep was obtained within one hour after administration, and in none were any bad after-effects noticed. In two cases of acute mania, in which the hypnotic effect of sulfonal was prompt and reliable, both patients had been given morphin injections and other hypnotics with no appreciable effect. In a case of epileptic mania, sulfonal was found to act much more promptly than bromidia, paraldehyde, or morphin, all of which had been previously given.—*Journal Nervous and Mental Diseases.*

Three Cases of Remarkable Anterior Spinal Curvature with Mental Aberration.—Dr. S. Weir Mitchell reports three cases, in each of which certain symptoms were present, such as mental failure, physical weakness, and rapidly developing and severe symptoms of spinal disease. In the first case, a girl of 13, there was a remarkable curvature of the entire spine, with protrusion of the abdomen, and the head carried back to enable her to see objects on a level with the eyes. There was no possibility of straightening her, either by passive efforts or through volition, but these efforts gave rise to no pain. The spine seemed to be rigid, allowing but little motion laterally; the head also possessed small power of rotation or flexion, but the neck-muscles were not rigid. Since her mental condition has improved, these peculiar symptoms are also present to a less extent. The second case presented nearly the same symptoms, except that the patient's spinal difficulty was altogether above the lumbar region, and that the symptoms were not of a hysterical type as in the first case. The symptoms in the third case were not as characteristic as those of the other two, but the resemblance was sufficient to justify the grouping; the three patients being more or less insane and all showing disorder of the vertebral column, which increased with the increase in the intensity of the mental symptoms, and diminished as these subsided; at the same time no organic disease appeared to be present.—*Medical News.*

FORMULÆ.

By Geo. B. Somers, M. D., San Francisco, Cal.

Three Coryza Prescriptions.—In a recent discussion before one of the Parisian medical societies, the three following prescriptions were given as having been found of value:

GRELLETY advised:

Betol	gm. 2.5
Menthol	gm. .25
Cocain	gm. .50
Powd. burnt coffee	gm. 1.5

BUCHARD recommended a snuff containing less cocain:

Bismuth subnitrate	gm. 15.
Camphor	gm. 5.
Cocain hydrochlorate	gm. .05

JULIEN preferred an ointment to a dry powder:

Vaselin	gm. 30
Boric acid	gm. 5
Menthol	gm. .05 to 20

—*Boston Med. and Surgical Journal.*

Dyspepsia of Nurslings:

Acidi hydrochlorici	m xxx
Aquæ	℥ iii
Syr. simplicis	℥ iiss

S.—Teaspoonful a quarter of an hour after nursing. Lactic acid may be combined with hydrochloric in the same formula, as follows:

Acidi lactici	m xv
Acidi hydrochlorici	m xv
Aquœ	℥ iii
Syr. simplicis	℥ iiss

S.—Give same as in above prescription.—*Riforma Medica.*

Rosacea.—PETRINIO uses:

Ichthyol	2 parts.
Resorcin	1 part.
Collodion flex.	30 parts.

—*Medical Record.*

Gonorrhea.—WATIER prescribes:

Antipyrin	gm. 10
Bichloride of mercury	cg. 10
Water	gm. 100

S.—Inject and let remain in the canal half an hour.—*Medical Record.*

Nerve Tonic in Debility:

Liq. strychniæ	m v
Liq. arsenicalis	m iii
Tinct. aurantii	m xx
Tinct. zingiberis	m x
Sp. chloroformi	m x
Aq. destillat	*ad* ℥ i

S.—For one dose twice daily after meals.—*Medical Press and Circular.*

Lucas-Championniere's Antiseptic Powder:

Iodoform,	
Powdered benzoin,	
Powdered cinchona,	
Carb. magnesium	āā equal parts.
Oil eucalyptus	few drops.

The odor is masked in this mixture. —*New York Medical Journal.*

Bleeding Piles:

Vaseline	℥i
Acetate of lead	gr.xx
Powdered opium	gr.xv
Balsam of Peru	ʒi

S.—Apply to piles after washing with cold water.—*Mathew's Medical Quarterly.*

Hemorrhoids:

Hydrochlorate of cocain	gr. xx
Sulphate of morphin	gr. vi
Sulphate of atropin	gr. iv
Tannin	gr. xx
Vaseline	℥i

S.—To be applied after each evacuation.—*Medical Press and Circular.*

Tonsillitis.—West uses:

Salicylic acid	ʒ ii
Bicarbonate of soda	gr. 75
Glycerine	℥ i
Peppermint water	℥ iii

S.—Tablespoonful every three or four hours.—*Union Médicale.*

Seborrheal Eczema of Scalp. Psoriasis and Favus.—Chotzen advises:

Alumnol	.5
Distilled water	1.5
Glycerin	3.
Lanolin pomade	15.

—*Medical Record.*

PUBLIC HEALTH.

By W. R. Cluness, M.A., M.D., San Francisco, Cal.

Mortality for April, 1894.—The deaths registered in 86 town districts of the State, during the month of April, in a population of 793,244, correspond to an annual rate of 16.80 a thousand, the total mortality having been 1,118. 70 deaths were due to zymotic diseases, giving an annual rate of 1.06 a thousand. Of these, 17 were due to diphtheria, 8 to cholera infantum, 8 to typhoid fever, 8 to diarrhea and dysentery, 10 to cerebro-spinal fever, 7 to whooping cough, 6 to croup, 1 to intermittent and remittent fevers, 3 to scarlet fever, 2 to measles, and 0 to small-pox. 350 deaths resulted from diseases of the respiratory organs, giving an annual rate of 5.29 a thousand. Of these, 210 were due to consumption, 101 to pneumonia, 36 to bronchitis, and 14 to pulmonary congestion; the rate being, for consumption and pneumonia, 3.12 and 1.52, respectively. 95 deaths resulted from diseases of the heart, 6 from alcoholism, 7 from erysipelas, 31 from cancer, and 474 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 582,200, was 17.70. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from Fresno and Sacramento, the lowest from Oakland.

METEOROLOGY.

Summary for April.—*Temperature.*—The normal temperature of the State for April is 57.7°, the average for April, 1894, was 59.6°; a departure from the normal of +1.9°. The highest monthly mean was 76°, at Indio; the lowest, 37°, at Cisco, in the mountain regions. The maximum was 103°, at Salton, on the 20th; the minimum, 15°, at Boca, in the mountain regions, on the 27th. The greatest monthly range was 63°, at Pleasanton; the least, 27°, at Point Lobos. The absolute range in the State was 88°.

Rainfall.—The normal precipitation for the State for April is 2.36 inches; the average for April, 1894, was 0.70 of an inch; a departure from the normal of —1.66 inches. The greatest monthly precipitation was 4.41 inches, at Crescent City; the least, nothing, at numerous places througout the State.

Wind.—The prevailing direction of wind was westerly and northwest.

Unusual Features.—The unusual meteorological feature of the month was the continued drought, which has been very injurious to all kinds of crops except fruits, which will be abundant.

Station at Keeler Discontinued.—Keeler station has been discontinued, and the station at Indio has been placed in the space for Keeler. Indio is a very dry place, the average humidity for April being but 18. The greatest humidity was 40 per cent. at 5 A. M., on the 27th, and the least was 7 per cent. at 5 P. M., on the 12th. The lowest dry point was 12° on the 17th, and the highest 44° on the 9th. Indio is 20 feet below sea level.—James A. Barwick, Director California Weather Service.

California—Tabular Statement for April, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn..........Cal.	61.6	85.0	40.0	---	---	---	---	1.35	---	---	---	---	N.W.	Southern Pacific Company.
Berkeley......... "	53.3	80.0	40.0	65.5	45.8	19.7	2	0.57	78.0	20	5	5	N.	Obs. University of California.
Colfax........... "	55.9	93.0	32.0	---	---	---	---	---	---	---	---	---	S.	Southern Pacific Company.
Eureka.......... "	49.0	64.0	36.0	54.0	44.0	10.0	12	2.97	95.0	9	10	7	N.	Weather Bureau Dept. Agr.
Fresno.......... "	62.0	92.0	38.0	76.4	48.3	28.1	3	0.10	52.0	20	7	3	N.W.	" " "
Indio............ "	75.7	99.0	50.0	89.6	61.8	27.8	0	0.00	18.0	28	2	0	W.N.W.	Rev Wm. Brennan.
Los Angeles.... "	59.0	85.0	41.0	70.0	48.0	22.0	2	0.13	74.0	10	14	6	W.	Weather Bureau Dept. Agr.
Monterey....... "	56.6	78.0	40.0	---	---	---	---	0.60	---	---	---	---	N.W.	Southern Pacific Company.
Napa........... "	60.5	84.0	39.0	72.5	48.5	24.0	2	0.61	70.0	22	4	4	S.	Station Napa Insane Asylum.
Oakland......... "	55.4	80.0	41.0	66.6	47.4	19.2	3	0.41	72.0	24	5	1	W.	Chabot Observatory.
Paso Robles.... "	58.0	87.0	30.0	74.0	43.0	31.0	2	0.24	46.0	22	3	5	---	Agricult. Experiment. Stat'n.
Red Bluff....... "	61.4	90.0	38.0	73.8	48.9	24.9	3	0.55	48.0	19	11	0	N.W.	Weather Bureau Dept. Agr.
Sacramento. ... "	61.3	86.0	39.0	72.6	50.0	22.6	2	0.34	56.0	19	7	4	N.W.	" " "
San Bernardino "	60.3	88.0	32.0	77.0	43.6	33.4	3	0.40	61.0	19	10	1	W.	A. K. Johnson, M. D
San Diego. ..... "	56.0	83.0	43.0	66.0	52.0	14.0	2	0.11	76.0	17	8	5	S.W.	Weather Bureau Dept. Agr.
San Francisco.. "	55.2	82.0	42.0	62.6	47.7	14.9	4	0.50	73.0	20	7	3	S.W.	" " "
Santa Barbara.. "	57.1	82.0	44.0	65.3	48.9	16.4	2	0.24	---	16	12	2	W.	Hugh D. Vail.
Santa Cruz...... "	58.1	86.0	36.0	72.5	43.7	28.8	3	0.66	---	24	3	3	S.W.	W. R. Springer.
Yuma..........A. T.	71.2	99.0	42.0	87.8	54.7	33.1	0	0.00	31.0	23	6	1	W.	Weather Bureau Dept. Agr.

T. means a trace of rain.   Blank (---) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: JUNE, 1894.

THE AMERICAN MEDICAL ASSOCIATION.

After an absence of twenty-three years, the American Medical Association will meet in San Francisco. At present every indication points to a successful meeting. At the time when an invitation was extended, at Milwaukee, it could not have been foreseen that a period of unexampled financial depression would overtake the country, and that with this would come the inevitable disturbance in commercial and agricultural pursuits, which reacts, perhaps, most directly upon our profession. The attendance, therefore, may not be so large as might be expected in more prosperous times. As an offset to this, the meeting will be held in the Midwinter Fair year, which provides a substantial attraction, and which has also insured more favorable rates, both transcontinental and local, than could be obtained at other times.

The coming of the Association has already created a very considerable activity in professional circles and in the various medical societies. There has been a marked increase of membership in many of the societies, some have been organized, others have been reorganized, one of the most important being the Nevada State Medical Society, a report of which will be found on another page. With all this there has been an increase of membership in the National Association, and we venture to say that a large percentage of this will be more permanent than can be demonstrated of the annual increment in the older States. It is as yet, perhaps, too early to talk of results; these must be reckoned after the meeting, but it is certain that an influence has been exerted in professional organization that will last long after this visit has become a pleasant memory.

The forty-fifth annual meeting has attracted much attention from the fact that at it would be submitted for action the reports of the Committees on Revision of the Constitution and By-laws and of the

Code of Ethics of the Association. We have kept these reports before our readers each month, and have discussed them in the different aspects from which the question can be viewed. A great deal of feeling has been excited by the proposed changes, and dire results are prophesied in case of failure to adopt very radical alterations in the fundamental principles of the organization. We do not take this view of the situation. While strongly opposed to many of the changes suggested, particularly those relating to the Code of Ethics, we believe that the Association will survive, and that it will progress as it has in the past, neither more nor less rapidly for mere changes in the written law. It would be satisfactory if every element of bitterness could be eliminated from the meeting. This will, to a great extent, be possible if the President rules, as we believe he must, that the report of the Committee on Revision of the Code must lie over for one year. In this, as in all efforts at harmony, he will have the hearty support of the profession of California, which needs no change in Code or in spirit on these debatable questions.

It has been said that when the Association was last on this coast the profession was divided, and that things were far from harmonious. It was fortunate that good manners prevented these disaffections from appearing on the surface, for the memories of that occasion seem to have dwelt most warmly in the hearts of all who came to San Francisco in '71. On the present occasion no such accusation can be raised. In the midst of hard times the profession has responded generously, and if we are less lavish than becomes the extravagant reputation of the State, it has not been because of want of inclination. Of social features an abundance has been provided, and all has been arranged to avoid interference with the real work of the Association. Nor have the ladies been neglected. Recognizing that the "Doctor's wife" shares with him his hardships, and that his calling throws upon her greater responsibilities than fall on others in the married sphere, the holiday of those who come will be made especially pleasurable. We believe that we shall be able to record a most enjoyable meeting, and in conclusion we have only to add that as the Association comes as the guests of the profession, it is to the profession alone indebted for its entertaintment.

NOTES

Dr. Albert Abrams.

Dr. Albert Abrams, of San Francisco, has gone abroad for a prolonged stay in Europe. He intends to resume practice about February 1, 1895. During his stay abroad Dr. Abrams will visit the principal medical centers of the old world, and will act as special correspondent for THE MEDICAL TIMES. In his absence his department will be conducted by Dr. H. E. Sanderson, San Francisco.

Nevada State Medical Society.

As a direct result of the coming of the American Medical Association to this coast the Nevada State Medical Society, that died of inanition several years ago, has been reorganized, and now gives promise of a healthy and permanent existence. In response to a call for a meeting of the physicians of the State to organize a State Medical Society, a meeting, which was well attended, was held in Reno, April 11, 1894. Dr. Pickard, of Virginia City, was elected temporary Chairman, and Dr. W. A. Phillips, of Reno, temporary Secretary. The constitution of the Society, adopted in 1878, was read, and, after some slight modifications rendering it more fitted to the present needs of the profession, was adopted. The following resolution was passed: "All regular physicians who make application before our next meeting, and whose credentials are passed upon by the Board of Censors as satisfactory, shall be placed on the list of members." The following were elected permanent officers: H. Bergstein, Reno, President; James Guinan, Carson, Vice-President; W. A. Phillips, Reno, Secretary and Treasurer; J. E. Pickard, Virginia City; B. Robinson, Reno, and M. Hirschberg, Virginia City, Board of Censors. The meeting then adjourned to meet, on the first Monday in July, at Virginia City.

Alleged Carelessness at the San Francisco Receiving Hospital.

Recently a Chinese woman, who had been shot in several places, was taken to the San Francisco Receiving Hospital for treatment. She remained under observation several days, and finally died. A *post-mortem* examination revealed the presence of a bullet in the brain. The autopsy surgeon maintained, in an interview with newspaper reporters, that the wound had not been treated. On the other hand, the assistant police surgeon, having the case in charge, is said by the newspapers to have replied that all the wounds had been treated, but that the patient had been so unruly and delirious as to tear away the bandages. He was further quoted as saying that he did not believe that a bullet was found in the brain. This quotation led the autopsy surgeon to continue the discussion by addressing a letter to the *Examiner*, in which he repeated his first assertions. Neither party to this discussion appears in a very dignified light. If the remarks of the hospital surgeon are quoted correctly, they seem to have been made at random, and the rushing into print on the part of the autopsy surgeon appears uncalled for. Whether the wound of the head was overlooked, or left entirely untreated, could not of course have been determined by a simple *post-mortem* inspection. That no operation was performed does not prove that the wound was overlooked. There may have been symptoms present which precluded operative interference. Granting that the case was carelessly handled, it is to be regretted that the parties concerned could not have discussed their views privately, or at least in the columns of the medical press.

The San Francisco "Home for Inebriates."

This institution has obtained unusual notoriety during the past few months. The newspapers have busied themselves with one sensation after another, wherein patients are said to have been abused, neglected, and improperly treated. A careful inquiry into the causes of the attacks reveals a condition of things somewhat as follows: The Superintendent, Dr. S. O. L. Potter, has offended a number of newspapermen, who have, from time to time, been detailed to get information concerning cases under treatment. He maintains that the institution is a private corporation, and that he is not bound to submit to interviewers, or give any information concerning cases under his care. He refuses to talk to the press representatives, and treats them in anything but a conciliatory manner. Lack of policy on the part of the superintendent seems, however, to be the principal cause of the attack on the institution. As for the charges regarding the treatment of the inmates, much allowance must be made. The stories of dissatisfied persons regarding public institutions are notoriously unreliable and exaggerated, but there is one point that is worth noticing, namely, the alleged unnecessary severity of treatment. A number of patients that have been sent to the Home for observation, and that have afterwards been discharged as sane, though testifying in the main to good treatment, have complained of being strapped to their beds when first admitted. It is possible that the practice of the institution in this respect errs on the side of overcaution. Insane persons, when under proper restraint, should be presumed harmless until they show themselves to be dangerous, and should be given as much freedom as is consistent with proper supervision.

MEMORANDA.

Crainiectomy for Acute Mania following Traumatism.

The following case has been to me very interesting, and the results of operative treatment fairly satisfactory. February 28, 1894, I was called to see George D——, aged 28, who was said to have "gone crazy." The case developed into one of acute mania. There was no history of hereditary insanity, and no suspicion of syphilis. The morals and habits of the patient were exceptionally good. He had always enjoyed excellent health until about a year ago when he was kicked by a horse, in the head, just in front of the right parietal eminence, since which time he has suffered much from headache, notwithstanding the prompt healing of the scalp wound. When not at work, his habit has been to rest his arms on a table and his head on his arms, in which position he would sit for hours without speaking. When asked why he did so, his answer was always, "My head aches." He referred the pain to the occipital and parietal regions on the right side, and told also of pain in left arm and leg, with distinct numbness of the left thumb and index finger. On examination I found a slight depression at the seat of injury. On April 14th, as the case was now one of apparently confirmed insanity, with the assistance of Drs. Thoma and Fee, I removed a portion of the skull, about an inch by an inch and a half in extent, without injury to the dura mater. The bone was abnormally thickened and the membrane presented an unhealthy grey appearance. The scalp wound was sutured, and it healed without suppuration. For the first twenty-four hours after operation, patient was perfectly sane. He then relapsed for a few days, after which continuous improvement began. At this date (May 15), he has seemingly completely recovered, except that on over-exertion or exposure to hot sun, he complains somewhat of pain in the head. The arm and leg symptoms have disappeared. The opening of the skull has refilled with bone. I have since thought that I should, perhaps, have removed a larger section of the skull.

W. H. PATTERSON, M.D.

RENO, NEV.

AMERICAN MEDICAL ASSOCIATION.

Membership in the American Medical Association.—"This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues and subscription for the *Journal*. Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly *Journal* of the Association will be forwarded regularly."

Application Blanks for Membership.—On advertising page xxvii we print a convenient form of application blank that is being circulated by the Association *Journal*, Any physician desirous of joining the Association can cut out this blank, and, having properly filled it, can mail same with his subscription to the Treasurer. As many physicians seem to be waiting for these blanks before joining the Association, it is pertinent to remark that the blank is not a necessity but merely a convenience. The essential is a certificate signed by the President and Secretary of a State or local Medical Society, and this, accompanied by $5, will be duly honored by the Treasurer. Meanwhile our readers will find the regular application form in our advertising columns, and we shall be at all times ready to afford any information in these matters.

Place of Meeting.—The Committee of Arrangements has secured Odd Fellows' Hall, corner Market and Seventh streets, as the place of meeting for the general sessions and the sections. This building furnishes one large hall with a seating capacity of 1,500, and twelve halls that can accommodate from 500 to 100 persons. There are also committee rooms in the building. This enables all the Association work to be carried on under the same roof, a very desirable feature that has not always been possible in other cities. It permits members to be present at different section meetings on the same day with the least possible loss of time, and by this concentration will tend to prevent stragglers. The acoustic properties of the main hall are good, and there is a large gallery for the accommodation of visitors.

Headquarters.—The headquarters of the Association will be at the Palace Hotel, corner Market and New Montgomery streets. It is, therefore, on the same street and just four blocks from the place of meeting. It should be mentioned that the whole of the Market-street system of cable cars traverses these four blocks—the Hayes, Castro, Valencia, and McAllister-street lines coming into Market street at Odd Fellows' Hall. This provides a car each way every few seconds, a service that is certainly not surpassed in any American city. The Registration Bureau, Association Post-office, etc., will be in Marble Hall, close to the hotel vestibule, and committees will meet in Parlor A on the first floor One of the many features of the Palace is its central covered court, which will make it pleasant for the ladies when going to or coming from the different entertainments.

Postoffice.—Station K is located in the Palace Hotel, on the office floor adjacent to the Registration room, where members can receive all mail matter by having it so addressed.

Hotel Rates.—DR. R. A. MCLEAN, chairman of the sub-committee on hotels, furnishes the following list which will be available, in addition to those already published in these pages, and which will be found at the end of this number:

	Single Rooms, with Board, per Day.	Suites.	No. of Persons to be Received.
Richelieu—O'Farrell and Van Ness Avenue	$3 00	$4 00	12 to 15
Lenox—628 Sutter street	1 50	2 00 to 2 50	8 to 15
Sutherland—S.E. corner Jones and Sutter	1 25 to 1 50	2 50	8 to 10
Alexandria—Jones and Sutter sts.	1 30	2 50	30 to 40
Westminster—614 Sutter street	2 00	2 50 to 3 00	5 to 6
Beresford—Cor. Bush and Stockton	1 50 to 2 00	....	10 to 15
Victoria—Sutter (near Jones)	0 75 (*Without Board*)	....	6 to 8

St. Nicholas, Market and Larkin streets—200 rooms; rates, American, $1.50 to $2.00; European, $1.00 to $2.00.

Mirabeau, corner Ellis and Leavenworth—15 suites; American plan only, $1.00 to $2.00.

Miramar, corner Geary and Leavenworth—20 suites; American plan only, $1.50 to $2.00.

Lyndhurst, 501 Geary street; 10 suites; American plan only, $1.25 to $1.50.

Berkshire, 711 Jones street, near Sutter—10 suites; American plan only, $1.50 to $2.50.

Colonial, corner Jones and Pine—5 suites; American plan only, $2.50 to $3.00.

Marechal Niel, corner Ellis and Jones—5 rooms; American plan only, $1.50 to $2.00.

Brooklyn, Bush street, near Sansome—10 rooms; American plan only, $2.00 to $3.00.

Itinerary of Excursions.—The Itinerary of Excursions, with cost of same, that was published in our issue of April, has led to so many inquiries that we decided to republish it in the two issues remaining before the meeting of the Association. It will, accordingly, be found after the last page of this number.

American Medical Editors' Association.—The annual meeting of the American Medical Editors' Association will take place at the Palace Hotel, on Monday, June 4at 8 o'clock. In the evening the Association and friends will be tendered a banquet by MR. R. E. QUEEN, of San Francisco. DR. C. H. HUGHES, of St. Louis, is President; DR. GEO. M. GOULD, of Philadelphia, Secretary; and DR. I. N. LOVE, of St. Louis, Chairman of the Committee of Arrangements.

Committees, National and Local.—The following is a complete list of the various committees, with the names of the members. Each committee will wear a distinctive badge, and members can at all times be found on duty in their respective departments.

Committee of Arrangements.—R. H. Plummer, chairman; G. L. Simmons, W. W. Kerr, W. R. Cluness, W. S. Thorne, H. Bert Ellis, R. A. McLean, J. Rosenstirn, H. Gibbons, Jr., J. H. Parkinson; R. L. Rigdon, Secretary.

Finance Committee.—H. Gibbons, Jr., Chairman; H. H. Hart, John Gallwey, G. W. Davis, J. H. Barbat.

Committee on Halls.—J. Rosenstirn, S. Stillman, B. F. Clarke, Luke Robinson, F. B. Carpenter, M. Krotoszyner, F. P. Wilson, A. W. Perry, W. C. Eidenmüller.

Committee on Transportation.—G. L. Simmons, T. W. Huntington, E. H. Woolsey, W. Winterberg, G. F. Shiels, T. B. DeWitt, M. Regensburger.

Committee on Registration.—W. S. Thorne, H. E. Sanderson, W. B. Lewitt, G. B. Somers, A. L. Lengfeld, J. T. McDonald, A. P. Woodward, N. Rogers.

Committee on Entertainments.—W. R. Cluness, Emmet Rixford, J. W. Keeney, W. J. Younger, Washington Dodge.

Committee on Exhibits.—R. L. Rigdon, C. C. Wadsworth, J. D. Hodgen, F. B. Sutherland, C. F. Griffin, M. L. Pettit, E. W. Thomas.

Committee on Printing.—W. W. Kerr, W. F. Cheney.

Committee on Hotels.—R. A. McLean, A. H. Taylor, W. H. Mays, W. F. Southard, H. N. Winton, S. P. Tuggle, O. H. Hund, A. A. D'Ancona, J. W. Hawkins.

Committee on Reception.—R. H. Plummer, W. Ayer, James Simpson, H. M. Fisk, C. L. Goddard, R. F. Verrinder, W. M. Lawlor, F. Bazan, C. N. Ellinwood, A. Barkan, A. T. Leonard, O. O. Burgess, J. D. Arnold, C. Cushing, Basil Norris, G. H. Powers, J. W. Robertson, J. O. Hirschfelder, Isaac Rivas, F. H. Titus, C. H. Steele, C. E. Farnum, T. F. Rumbold, R. W. Murphy, P.

De Vecchi, David Cohn, George Chismore, M. A. Cachot, E. L. Parramore, San Francisco; A. Hartsuff, Deputy Surveyor-General U. S. A., Medical Director Department of California; J. V. D. Middleton, Deputy Surveyor-General, San Francisco, U. S. A. Presidio; I. M. Procter, Petaluma; R. P. Smith, Jr., Santa Rosa; R. S. Markell, Cloverdale; L. W. King, Ukiah; A. H. Pratt, George C. Pardee, F. L. Adams, J. H. Wythe, Oakland; W. P. Gibbons, Alameda; Medical Inspector G. W. Woods, U. S. N., Mare Island; A. M. Gardner, E. Z. Hennesey, Napa; H. M. Pond, St. Helena; F. W. Mitchell, Calistoga; C. W. Kellogg, Lakeport; H. D. Lawhead, Woodland; L. P. Tooley, Willows; John Fife, Red Bluff; J. H. Miller, Redding; C. H. Wheeler, Sissons; C. W. Nutting, Etna; C. L. Gregory, Yreka; Oscar Stansbury, Chico; David Powell, E. E. Stone, Marysville; D. Shoemaker, Truckee; R. M. Hunt, Nevada City; T. M. Todd, Auburn; W. A. Briggs, W. E. Briggs, Thos. Ross, Sacramento; Asa Clarke, Stockton; W. N. Sherman, E. S. O'Brien, Merced; C. W. Evans, Modesto; A. J. Pedlar, Chester Rowell, Fresno; W. H. Cook, Bakersfield; H. Bert Ellis, H. S. Orme, J. P. Widney, W. L. Wills, Jos. Kurtz, Los Angeles; Walter Lindley, Whittier; S. G. Huff, San Bernardino; K. D. Shugart, Riverside; C. M. Fenn, C. C. Valle, San Diego; C. L. Bard, Ventura; S. B. P. Knox, R. J. Hall, J. M. McNulty, Santa Barbara; W. W. Hayes, San Luis Obispo: W. T. Lucas, Santa Maria; S. J. Call, Paso Robles; J. H. Tebbetts, Hollister; G. B. Richmond, Salinas; J. L. Ord, Monterey; C. H. Anderson, Santa Cruz; R. P. Gober, Los Gatos; R. Caldwell, J. U. Hall, Jr., H. J. B. Wright, San José; T. D. Wood, Palo Alto; F. W. Hatch, Agnews.

Ladies' Committee of Arrangements.—Mrs. Henry Gibbons, Jr., Chairman; Mrs. R. H. Plummer, Mrs. G. L. Simmons, Mrs. W. W. Kerr, Mrs. W. R. Cluness, Mrs. W. S. Thorne, Lula T. Ellis, M.D., Mrs. R. A. McLean, Mrs. J. Rosenstirn, Mrs. J. H. Parkinson, Mrs. R. L. Rigdon.

Associate Committee.—Mrs. C. G. Kenyon, Mrs. O. O. Burgess, Mrs. Washington Dodge, Mrs. J. D. Arnold, Mrs. C. N. Ellinwood, Mrs. A. L. Lengfeld, Mrs. W. J. Younger, Mrs. W. E. Hopkins, Mrs. W. Winterberg, Mrs. J. T. McDonald, Mrs. L. L. Dunbar, Agnes Lowry, M.D., Isabel Lowry, M.D., Charlotte B. Brown, M.D.

The headquarters of this committee will be in the general reception room, Palace Hotel, where members of the committee can always be found.

Entertainments.—The following entertainments have been provided for the visitors, in which it is hoped all will participate:

Tuesday evening, June 5: The San Francisco County Medical Society will give a reception to the Association, thus welcoming them to San Francisco. The reception will be held at Pioneer Hall, on Fourth street, below Market. The whole building, including the Mining Bureau, will be thrown open, and the visitors will thus have an opportunity of inspecting many interesting relics of early days. An orchestra will be stationed in the large hall, providing music for dancing and promenade. Supper will be served downstairs, buffet style.

Wednesday evening, June 6: Cooper Medical College will receive the Association at the college building, Sacramento and Webster streets. Visitors will be extended the freedom of the college, the whole building, as well as the Lane Hospital adjoining, which is now almost completed, being thrown open for the occasion.

Thursday evening, June 7: The Association will visit the Midwinter Fair at Golden Gate Park. All the buildings will be open and will be illuminated. The grand court and the electric tower will also be illuminated for the occasion.

Friday evening, June 8: The Medical Department of the University of California will give a reception at the Hopkins Institute, on Nob Hill. Music will be provided and refreshments will be served during the evening. The whole building will be thrown open so that visitors will be enabled to see the pictures and other works of art.

Saturday, June 9: The medical profession of the State of California, through the various medical societies, will give an excursion on the bay. The steamer Newark, of the Southern Pacific Company, one of the largest, and the fastest steamer on the bay, has been engaged for the occasion. The steamer will leave the foot of Market street at 9 a. m. sharp, and will first proceed up the bay to Hunter's Point, stopping at the Union Iron Works and at the Sugar Refinery, and returning along the water front so that the city can be viewed from the water. The boat will then steam down the bay to the Heads, showing the Gate, Fort Point, and the Presidio reservation, then turning, in smooth water, she will head for Raccoon Straits, passing Alcatraz, and stopping at the United States Quarantine Station; thence up the bay along the Marin county shore and having cleared the land she will head for Mare Island, where a landing will be made. Time will be allowed here for visiting the Navy Yard and the United States Naval Hospital. When the visitors have embarked the steamer will turn for home, passing down the Contra Costa county shore, then Berkeley and Oakland, again crossing the bay to San Francisco. This excursion can be enjoyed by the most timid, as the early morning, which is always fine in June, will be spent around San Francisco, and the afternoon in the calm waters of San Pablo Bay. Music will be provided, and refreshments of a substantial character will be served on board during the day. Irving M. Scott of the Union Iron Works, J. D. Spreckels of the Sugar Refinery, Deputy Surveyor-General J. V. D. Middleton, U. S. A., and Medical Inspector G. W. Woods, U. S. N., will accompany the excursion and will furnish information to visitors in their respective spheres.

Cards for the various entertainments, and tickets for admission to the Fair on Thursday evening, can be procured from the Committee of Arrangements at headquarters.

In addition to the various evening entertainments at which the ladies will be present, the following have been arranged for their special benefit:

Tuesday, June 5.—Drive to Golden Gate Park, Ocean Beach, Presidio Reservation, and other points of interest. Carriages will leave Palace Hotel at 1 P. M.

Wednesday, June 6.—"Tea" given by the Ladies' Reception Committee to the ladies of the American Medical Association, at the residence of Mrs. R. A. McLean, Pacific Avenue, between Devisadero and Broderick, from 2 to 5 P. M. Take Sutter street car, and transfer to Polk and Pacific Avenue.

Thursday, June 7.—Visit to Midwinter Fair.

Friday, June 8.—Reception at Sutro Hights given by Mr. Adolph Sutro to the ladies of the American Medical Association. A special car will leave the Baldwin Hotel, corner Market and Powell streets, at 10:30 a. m. sharp. Guests will show card to conductor.

Cards for the tea, and for Mr. Sutro's reception, may be obtained at the Ladies' Headquarters—Monday, Tuesday, and Wednesday mornings.

Ladies wishing to do shopping, or to visit Chinatown, can obtain desired information at the headquarters of the committee.

Association Button and Badges.—The Association button will be of silver from a very effective design by Messrs. Geo. Shreve & Co., the well-known jewelers, who are also responsible for the execution of the work. The design shows the Golden Gate, with the Heads on either side, indicating the "City by the Gate," in which the Association will meet. In the center the bear also appears, this symbol of the Bear Flag indicating the participation of the whole State in welcoming the Association. Below is seen the Geneva Cross, which has for many years been identified with the medical profession in peace and in war. The letters A. M. A., San Fracisco, and the date, 1894, complete the design. The *President's button* will be of gold with red enameled cross. *Officers of the Association*, silver with red enameled cross. *Officers of Sections*, silver with golden cross. *Members*, silver button or pin. The *State badge*, or ribbon, on which is printed the name of the State from which the member hails will be poppy colored, or of the same shade as the California poppy (*Eschscholtzia Californica*), the State flower. *Delegates* from affiliated societies will in addition wear a narrow white ribbon, on which will be printed the word "Delegate."

Committee Badges.—The various local committees will wear a distinctive badge, so that visitors in search of information can readily identify the particular committee sought. The following are the badges: *Committee of Arrangements*, blue ribbon, gold lettering. *Sub-Committees* on Finance, Halls, Transportation, Registration, Entertainment, Printing, Exhibits, Hotels, Reception, lavender ribbon, with name of committee on badge.

The Ladies' Committee will wear the Association badge and button, and in addition the committee badge with appropriate lettering.

Private Entertainments.—There will no doubt be several private entertainments during the meeting, though the only one so far announced is that by DR. W. F. MCNUTT. Dr. McNutt will entertain the Association at his residence, 1805 California street, on Wednesday evening, June 6. The San Francisco Gynocological Society will entertain the Section on Obstetrics and Diseases of Women at breakfast, at the Baldwin Hotel, from 1 to 3 P. M., Thursday, June 7. The annual dinner of the Sections on Ophthalmology and on Laryngology will take place on Wednesday, June 6. The place will be announced hereafter, as well as price of tickets.

Special Invitations.—Special invitations to the Association keep pouring in. Amongst those not already announced are the following: DR. H. W. HARKNESS, President of the California Academy of Sciences, invites the Association to visit the Academy, at 815 Market street, and inspect their very interesting collection. MR. IRVING M. SCOTT, of the Union Iron Works, where the United States cruiser Olympia and the battle ship Oregon are now in process of construction, will be glad to see any members of the Association interested in marine architecture and in our new navy. It may not be generally known that the battle-ship Illinois, so familiar at the World's Fair, at Chicago, was really a model of the Oregon. PRESIDENT MARTIN KELLOGG, of the State University, will be glad to see members of the Association at Berkeley. DR. DAVID STARR JORDAN, President of the Stanford University, has asked the Association to visit Palo Alto. The location of Palo Alto, with directions for reaching same, will be found in our itinerary of excursions. The medical officers of the United States Army, stationed at San Francisco, have invited members of the Association to visit any and all of the army posts about the bay.

The Exhibition.—An exhibition, such as is usually held in connection with the meeting of the Association, will be found on the ground floor of Odd Fellows' building. The following well-known firms have been assigned space: W.

D. Allison Co., physicians' office furniture, appliances, etc.; The Howard Co., surgical chair; W. B. Sanders, J. B. Lippincott Co., medical books; W. Hatteroth, J. H. A. Folker, W. H. Armstrong Co., surgical instruments; Humboldt Mineral Water Co.; R. W. Gardner, McKessons & Robbins, W. R. Warner & Co., C. E. Worden & Co., Sultan Drug Co., Dias Chemical Co., pharmaceutical preparations; San Francisco Artificial Limb Co., artificial limbs and surgical appliances; California Grape Food Co., unfermented grape juice; Horlick's Food Co., malted milk; Tarrant & Co., Tarrant's Hoff's malt extract; Clam Juice Food Co., clam juice; Coronado Springs mineral water; Highland Springs Mineral Water Co.; Mellier's Food Co.; R. Hoppe. special form of splint; Reed & Carnrick; John Wyeth & Bro. There are several other intending exhibitors who have not as yet made definite arrangements.

Highland Springs.—Highland Springs is situated in an arm of the great Clear Lake Valley, in Lake county, and has long been recognized as a pleasant and invigorating health resort, apart from the medicinal value of its waters. The management is desirous that members of the Association should pay them a visit. Mr. J. Craig, the manager, states that if a party is formed he will procure the lowest possible railroad rates, and will extend the limits of his hospitality *free* to the visitors during their stay at the Springs. This courtesy has been extended through Dr. H. D. Lawhead, of Woodland. The attractions of Lake county—often called the Switzerland of America—are many and varied, and will well repay even a brief visit.

The itinerary will be as follows:

Leave San Francisco (Tiburon Ferry)	7:30 a. m.
Arrive Pieta	12:00 m.
Leave Pieta (by stage, 12 miles)	1:00 p. m.
Arrive Highland Springs	2:30 p. m.
Returning, leave Highland	10:30 a. m.
Arrive Pieta	12:00 m.
Leave Pieta	1:00 p. m.
Arrive San Francisco	6:00 p. m.

Hotel Del Coronado.—An itinerary of California resorts and points of interest would be very incomplete were Coronado left out. When San Diego, with its beautiful hotel, was included in our itinerary we were unable to state that a special reduction would be offered to visiting members of the Association. We have now the assurance of Mr. E. S. Babcock, the manager of the Hotel Del Coronado, that "a special reduced rate will be made to any members visiting the hotel." There have been many nice things written and spoken about Coronado, but none that exceed the claims of that delightful place. We strongly urge every member of the Association who goes to Southern California, not to leave without seeing San Diego.

Points of Interest in and Near San Francisco.—In addition to those points of interest that have been mentioned in our itinerary, the following in San Francisco and its immediate vicinity have been noted: Academy of Sciences, 815 Market street. Bank of California, California and Sansome streets; one of *the* financial institutions of this country. Fire Patrol; drill daily at 12 M. sharp; corner Stevenson and Ecker streets. Bancroft Library, Valencia, near Army street; 30 years in collecting; cost half a million dollars; to index it cost $39,000. Collection occupies one mile of shelving. Alaska Commercial Co., 310 Sansome street; museum of Alaska Curios; by invitation the A. M. A. may visit and be conducted through at any time. Geo. C. Shreve & Co., Market and Post streets; elegant display of bronzes, bric-a-brac, statuary, etc. manufacturers of the Association buttons. Society California Pioneers, No. 5 Pioneer Place, Pioneer Building, off Fourth street, near Market; library, cabinet of minerals, relics of early times, various other objects of interest. Golden Gate Park, 4 miles long, bordering on the Pacific ocean. Andrew's Diamond Palace, No. 221 Montgomery street; the most unique and gorgeous affair of its kind in this country. Mechanics' Library, 31 Post street, between Montgomery and Kearny; 50,000 volumes scientific and literary works, including many rare copies; reading rooms, chess room, etc. Olympic Athletic Club, Post street, near Taylor street; one of the leading athletic clubs of the world; ranks among the first of the social organizations of the city. California State Mining Bureau, Pioneer Building, Fourth, near Market street; specimens of all geological and mineralogical substances, fossils, Mexican mummies, meteors, casts of largest gold nuggets, hundreds of rare and interesting specimens; open 10 A. M. to 5 P. M., free. Alcatraz Island, military post, and one of the government fortifications in the Bay of San Francisco; a visit will prove interesting; the steamer "Gen. McDowell" makes two trips daily, for which no charge is made; permission to visit the island and such information as is wanted can be obtained at the government offices, in the Phelan Building, corner Market and O'Farrell streets, or from the Committee of Arrangements· Mission Dolores, old adobe Catholic church, Sixteenth and Dolores streets; this very ancient Mission was founded by Father Junipero Serra, the father of the California Missions, on the 9th of October, 1776; at the organization, fifteen soldiers were stationed at the Presidio for its protection; a cemetery is attached, in which first interment was made in September, 1776; first Indian convert was baptized 27th December, same year. Midwinter Fair in Golden Gate Park. Fort Point and Presidio Reservation. Sutro Hights, baths, seal rocks and Cliff House. Telegraph Hill, in the northeastern corner of the city, is 296 feet high, and from its summit the best view of the water front and business portion of the city can be obtained; the Golden Gate and the Pacific ocean, nearly all of both arms of San Francisco Bay, part of San Pablo Bay, the Contra Costa Mountains for a distance of thirty miles, Mount Diablo, the Suscol Hills, the hills beyond Napa Valley, the range between Napa and Sonoma, the plains of San Pablo, and Alameda, Oakland, Berkeley, San Leandro, San Lorenzo, Haywards, and various other villages are visible; the best time for going to the Hill is about 9 o'clock on a clear morning. University of California, at Berkeley; library of 33,000 volumes is constantly augmented by gift and purchase, especially from the income of the Michael Reese Fund of $50,000. State Board of Trade, 602 Market street, opposite the Palace Hotel ; a cordial invitation is extended to visiting members to inspect this most interesting exhibit, where every attention will be paid them by the gentlemen in charge.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, April 24, 1894.

The President, W. F. WIARD, M.D., in the Chair.

New Members.—J. D. REED, M.D., J. S. JADAROLA, M.D., and H. D'ARCY POWER, M.D., were duly elected members of the Society.

DR. F. B. SUTLIFF read a paper on "Catarrhal Pneumonia in Children, with Reference to a Special Form of Treatment." [To be published.]

Dr. G. L. Simmons, in opening the discussion, said: Many years ago I used veratrum viride quite extensively, but of late years have rarely prescribed it. Twenty years ago, Dr. Cutter, of New York, went to Vienna, and when there wrote a paper on the use of veratrum viride in catarrhal pneumonia and capillary bronchitis. He was assigned some cases at the Vienna General Hospital, in which this method was tried, but it was found that the percentage of recoveries under tonic and expectorant treatment was as good. I can take patients suffering from this trouble, and with warm fomentations—quinine and expectorants—can reduce the temperature and accomplish the same results reported by the author. In these cases it is very important to maintain the heart's action, and for this reason I do not give veratrum viride. Several years ago the late Dr. Oatman read a paper before this Society, on the the action of veratrum viride in puerperal convulsions, and I remember he used the expression that the patient "was bled into his own veins." This drug is a powerful cardiac depressant, and should be used with great care.

Dr. T. A. Snider: Some years ago I was in the habit of using veratrum viride quite freely, and believed that I derived great benefit from its use. In some cases, however, the action of the drug was quite alarming, and it was necessary to use stimulants in order to overcome the depression. I have now totally abandoned its use. In these cases I now give quinine, antipyretics and stimulants, sometimes using aconite in the incipient stages.

Dr. M. Gardner: I have not discarded veratrum entirely. My principal objection to its use in children is that you should be there to watch its action. It is a very dangerous remedy, and one whose administration cannot be entrusted to the average nurse or parent. I think we have other remedies that are equally effective.

Dr. G. A. White: I have not used veratrum in the past 10 years in pneumonia; I depend upon stimulating treatment: carbonate of ammonia and expectorants, with a jacket poultice and counter irritation. Dover's powder or morphine may be required if the case is severe. Ordinarily this disease is self-limited, and we cannot cut short the attack by any treatment.

Dr. C. B. Nichols said he was glad that the author had brought forward a certain line of treatment, and he hoped to see more papers of this character read before the Society, as they were both practical and instructive. Catarrhal or general pneumonia in a young child is usually cut short by death. He had seen cases where veratrum was given with very beneficial results. In one case he had given the drug until vomiting set in, which nearly ended fatally.

Dr. C. E. Fowler said that Hare, in his system of therapeutics, used the same expression that had been ascribed to Dr. Oatman. The remedy could be given with safety in robust children and in adults, but it was very dangerous in weak patients.

Dr. Thomas Ross: In the practice of medicine we are apt to run in ruts. Twenty years ago I used veratrum in pneumonia and in all inflammatory diseases. Norwood's tincture was the favorite prescription. It has now been almost entirely abandoned in the treatment of these, diseases because it is a dangerous and powerful cardiac sedative, and we must, therefore, watch the heart's action closely. I have not used the drug for 12 years. In pneumonia we should sustain the patient by every means. High fever may require cold-sponging and even the wet pack. Opium should certainly be given in cases of restlessness or severe cough. Quinine is certainly useful in children. If the patient be sustained, the disease will run its course. Lobular pneumonia is a dangerous disease, and often proves fatal.

Dr. H. W. Strader: In that part of Nebraska where I formerly practised, the daily range of temperature was excessive. There would occasionally be a change of 50° in 24 hours. Pneumonia was a common disease and was usually very severe. In these cases I used often to blister freely with cantharides. Veratrum is one of the best remedies, but it is dangerous, and, if the patient is feeble, I prefer aconite. Opium in any form should not be given in these diseases, as it prevents expectoration. When giving veratrum or aconite we should make it a point to see the patient frequently. I believe that I have often succeeded in cutting this disease short.

Dr. J. H. Parkinson: As I understand the paper, it treats only of catarrhal pneumonia in children. In this disease I have used veratrum freely, and sometimes the benefit has been so marked as to lead one to doubt the accuracy of the diagnosis. I use the fluid extract in small doses, frequently repeated. Regarding the disuse of remedies and methods by the profession, it is not so much that our methods of treatment have changed as that methods and remedies have been replaced by newer and more effective drugs. Many years ago bleeding was a routine practice in certain cases. Antimony was used for the same purpose, namely, depressing the heart's action. These methods were employed in acute inflammatory conditions to arrest the inflammation, check fever, or relieve pain. Later on, veratrum and aconite were employed for the same purpose. These methods have now been replaced, in some cases, by morphine, and in others by the coal-tar products, which are equally efficacious. In giving veratrum, I have found the most satisfactory results from small doses frequently repeated; but, as has been stated by a previous speaker, it is unsafe to leave the administration of this drug in incompetent hands.

DR. W. A. BRIGGS: In February, March and April of 1885, we had a severe and extensive epidemic of catarrhal pneumonia in children. In common with other practitioners, I treated quite a number of cases, and lost several of them. I felt at that time that the means at my hand were certainly defective. I used the stimulating plan, with expectorants, and saw a large number of them die. In all cases where the respirations ranged from 60 to 95 per minute, death was almost certain to follow. At this time the late Dr. Agard, of Oakland, spoke to me of the marked benefit of veratrum and ergot in these cases, In the early years of my professional life I had used veratrum, but had abandoned it, as it caused nausea in adults. Under Dr. Agard's recommendation, I resumed its use, and since then I have treated a large number of cases with it. With the exception of one case of recurrent secondary pneumonia, I have not lost a single case of catarrhal pneumonia in children. I believe that children tolerate the drug far better than adults. To one patient, whose respiration was 90, pulse 144, I have given ¼ to ⅓ of a minim hourly, until the respirations went down to 60. I have no fear of this drug in children. I have used Norwood's tincture, and have given ¼ of a minim hourly to a child, one year old, whose respirations were 108 per minute for 72 hours, at the end of which time the respirations had been reduced to 60, and rapid convalescence followed. I have never seen a fatal result or any case that I would class as dangerous. It depresses the respiratory center and may often cause Cheyne-Stokes respiration. Catarrhal pneumonia, in my observation, is not fatal from heart-failure, but from respiratory failure. On the contrary, croupous pneumonia causes death by cardiac failure. With veratrum, as has been already stated, we bleed the patient into his own veins, and diminish the arterial tension, and this can be continued for days at a time. In severe cases we may keep the patient under veratrum for 10 days. I would strongly urge the use of this drug in the early stages of capillary bronchitis. For a child one year of age I would prescribe:

Tr. Verat. Virid. (Norwood's)	ms xv.
Tr. Opii Camph.	ʒ iii.
Spts. Eth. Nit.	ʒ iii.
Syr. Tolutan ad.	℥ ii.

S.—15 drops hourly.

If nausea or restlessness are produced, diminish the dose. It rarely happens that this dose causes any untoward symptoms in a child, although it corresponds to a 3-minim dose for an adult, which would cause emesis in a short time. Spirits of niter diminishes the action of the vagus center, while veratrum produces vasa-motor depression and dilatation of the arterioles. My success has been so uniform that I cannot help recommending it most highly.

THE PRESIDENT: I remember a classmate of mine writing a thesis on the subject of veratrum. In order to accurately describe its effects, he took 5-drop doses of the tincture every hour, and then 10-drop doses, which latter caused severe emesis. I believe there is no fatal case reported from the use of veratrum. I have often seen it produce emesis in the adult, but no alarming symptoms resulted. In cases of pneumonia I shall depend on hot applications, feeding the patient as much as possible, and giving strychnine and carbonate of ammonia. No matter what treatment is adopted, we will frequently meet with bad results.

DR. SUTLIFF, in replying, said he did not recommend veratrum in pneumonia, but only in capillary bronchitis or catarrhal pneumonia in children. He was aware that he could let them get well, but he believed in making them get well, and he felt that this was the best way to do it.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular meeting, April 10, 1894.

The President, WM. WATT KERR, M.D., in the Chair.

New Members.—S. C. MISH, M.D., L. A. KENGLA, M.D., MARK L. PETTIT, M.D., and P. M. JONES, M.D., were duly elected members of the Society.

American Medical Association.—The question as to the particular form of entertainment that should be tendered to the American Medical Association, and for which, as has already been stated, the sum of $1,500 was appropriated, was discussed at some length, but in view of the small attendance at the meeting it was decided to postpone definite action until a later date.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, February 17, 1894.

The President, JOHN F. MORSE, M.D., in the chair.

Pathological Specimens—Renal Cysts.—DR. MAX SOLOMON presented some pathological specimens, and read their histories. In the first case, the peculiar feature was that there was no appearance during life of the suffering that would ordinarily attend such a pathological condition. The patient was 83 years old. He was practically well on February 7, at 7 P. M., but for a weak pulse. He died at 3 A. M. the following day. On *post-mortem* examination there was found an atheromatous deposit on the aortic valves. If it had caused stenosis there had been no indications of it by former physical examination. The kidneys were in bad condition. In the left there were cysts, and a small one had burst. In the liver there was quite a good-sized gallstone. As a rule, a cyst of this size in the kidney is rare, and it should cause more disturbance than was present in this case.

DR. DUDLEY TAIT: I fully agree with Dr. Solomon as to the rarity of larger cysts of the kidney, but as he says the smaller ones are more frequent than one would suppose, and most authorities claim it impossible to diagnose them. Generally with arterio-sclerosis in old people we find cysts in the kidneys. Possibly if a microscopical section should be made of this kidney there would be found an arterio-sclerosis, and the cyst might be traced to an endarteritis. As to the gall stone, they are frequent in old age. After 60 or 70 years 45 per cent. out of 100 have them.

DR. W. WATT KERR: The whole kidney may be destroyed and no symptoms relative to that organ be manifested. I have seen cases apparently suffering from other troubles, where on *post-mortem* examination the whole kidney was found to be a mass of multilocular cysts, the formation being absolutely destroyed, the healthy kidney doing all the work. The whole surface as well as the internal structure was affected. Apparently the disease was not malignant.

DR. T. C. RETHERS: In Berlin at an autopsy a cyst fully 10 inches wide was found that had given rise to absolutely no symptoms during life, the patient dying from apoplexy.

DR. E. E. KELLY: I have never seen an entire dissolution of the kidney. In one case seen by Dr. Howitt and myself there was a hydronephrosis, which was diagnosed by aspiration, and subsequent examination of the liquid thus obtained, and an interstitial nephritis was present, albumin being in the urine before aspiration. The case previous to our examination had been diagnosed as tubercular peritonitis from the distension of the abdomen and the fluid in the lower part. The patient was tapped, and three quarts of uriniferous and purulent matter drawn off. I believe that these cysts all develop from some affection of the tubules, and it might be possible for a serous cyst to thus form from the substance of the kidney. I saw an interesting case in Chicago last summer, somewhat different from these under discussion. Patient, a male, had suffered a long time with general debility, and no definite results were arrived at. Dr. Sherwood found, on examining the urine, the bacillus of tuberculosis, and diagnosed tubercular nephritis, and on further physical examination the right kidney was found enlarged. It was suggested that it be removed, which was done. It was greatly enlarged, being 6 inches in diameter, and aside from the kidney substance it contained 18 ounces of purulent matter full of tubercle bacilli. This was the first case I had seen where the tubercular condition of the kidney was diagnosed by examining the urine.

Glanders—Farcy.—DR. DUDLEY TAIT: I have now in the French Hospital a rare case, should the members like to see it, a case of acute glanders. The affection dates back 18 days; it is very typical; no symptoms are wanting; in all probability she will die to-morrow. I have also a case of chronic glanders or farcy, which may be curable. I arrived at the diagnosis of the case from the symptoms, which are well marked. The patient, a woman, was confined January 3, 1894, being out on the 12th. Fifteen days ago she experienced severe frontal headache, a vesicular eruption developing into a condition of of pemphigus, the vesicles suppurating, and terminating in a phlegmonous slough of the forehead. The eyelids were very much congested, and the mucous membrane secreting a characteristic ropy pus, as seen in glanders of horses. The case was diagnosed by exclusion from pyemia, syphilis, lupus tuberculosis and erysipelas. The cultures are not ready yet, but I have succeeded in getting the bacillus. I inoculated some guinea pigs 48 hours ago.

A Hemorrhagic Eruption Accompanying Quinsy.—DR. W. WATT KERR: I wish to report a peculiar complication of a common disease. Last month a woman, 32 or 33 years of age, came to the hospital with what was evidently a quinsy, but in my absence she was isolated as diphtheritic. The peculiar point is that as the throat began to get well, hemorrhagic spots, as in scurvy, appeared from the knee to the ankle. She volunteered the information that always after quinsy, which she had had two or three times a year for years past, these spots appeared; in a week they would disappear. There was no history of syphilis.

Removal of the Tonsil with the Actual Cautery.—DR. DUDLEY TAIT: I would like to inquire if any member has had experience in removing tonsils with the actual cautery. In some 50 cases I have removed them by this means at three or four sittings, without pain or hemorrhage. I have used the cautery in phlegmon of peritonsilar tissue. There is no danger even in the acute stage.

DR. W. A. MARTIN: I have not had much experience with the actual cautery, but frequently use the galvano-cautery. I have opened an abscess of the tonsil by this method. I have also used it in the lacunar form of tonsilitis, and sometimes meet with cure by it. If not, I have to keep on burning if the disease recurs.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular meeting, April 12, 1894.

The President, ALBERT ABRAMS, M.D., in the Chair.

New Members.—GRAILY H. HALL, M.D., San José; RALPH T. ORVIS, M.D., Alvarado; TULLIO ROTTANZI, M.D., and MARK H. WOOLSEY, M.D., of San Francisco, were duly elected members of the Society.

Traumatism followed by Secondary Cataract—Cholesterine Crystals in the Anterior Chamber.—DR. A. BARKAN presented a case of traumatism of the eye followed by secondary cataract and the presence of cholesterine crystals in the anterior chamber. Eight years ago the patient's left eye was struck with a rope's end. Some contusion and inflammation resulted, but the eye was blind at once. The pain and inflammation subsided, but after two years cataract formed. He now comes to be treated for commencing ordinary cataract in the other eye. Examination here shows no complications, but as the cataract is not yet ripe, operation will be deferred. The left eye shows cholesterine crystals floating in the aqueous humor, which in daylight are visible to the naked eye. The lens is opaque, the iris is attached to the lens; there is complete detachment of the retina and there is absolutely no appreciation of light. We cannot tell whether there are cholesterine crystals in the vitreous, because of the opacity of the lens, but they are probably present, for the vitreous is a favorite site for the disposition of cholesterine. The crystals do not sink to the bottom of the anterior chamber, but float in the aqueous humor, and when the eye moves they dance about in front of the iris, making it seem as if the iris trembled. The deposition of cholesterine in the eye generally follows traumatism.

Dr. F. Z. Bazan suggested that the cholesterine might be derived from the blood effused into the eye after an injury, for it has been shown blood corpuscles contain cholesterine.

Dr. Barkan said that cholesterine can be extracted from normal vitreous humor, and in fact crystals are occasionally deposited in the normal eye. It is not certainly known whether the crystals are formed within the eye, but there is evidence for that view. This patient has no cholesterine in the right eye.

The President said cholesterine is found normally only in the bile, where it is held in solution. It constitutes about 50 per cent. of all gall-stones. Pathologically, cholesterine crystals are found in nearly all pathological new-formations, and are closely related to fatty degeneration. The symptoms of biliary intoxication are due to the presence of cholesterine in the blood, whence the designation cholesteremia. How the crystals are deposited and why, are questions as yet not definitely answered.

Dr. R. L. Rigdon read a paper entitled "The Causes of Frequent and Painful Micturition." [To be published.]

Dr. C. F. Griffin spoke of those cases of frequent micturition due to stricture. The man has one or more attacks of gonorrhea followed by a stricture. Behind the stricture there is apt to be left a spot, the seat of chronic inflammation, kept up by a number of conditions, the chief of which is poor drainage. The irritation on the nerve terminals of this chronically inflamed spot causes, in many cases, frequent micturition, more especially if the stricture is near the meatus or in the posterior urethra. Stricture in the penile portion of the urethra does not generally cause interference with the function of urination. If asked to determine whether a person with stricture can safely marry, several points should be considered. These cases always have some discharge. Otis says that any muco-purulent discharge from the urethra may be capable of communicating a catarrhal inflammation of greater or less severity to any woman. Lockhart has produced pseudo-gonorrhea and epididymitis from pure cultures of staphyllococci and streptococci, the cases not differing in appearance from ordinary gonorrhea. If a man have gonococci in his discharge he may not marry; if he have discharge and no gonococci he may not marry; if he have stricture and a discharge he may not marry; if a man have stricture and no appreciable discharge, but have frequent micturition, he may not marry; if a man have a stricture and no discharge, and no frequent micturition, he may marry.

Dr. Geo. Gerlich said that in cases of eneuresis he had found the remedy simple enough. The alarm clock is set to ring at a little before the time the child is expected to wet, and when the time comes he is made to get up. The remedy is simple but it is efficient.

Dr. H. Gibbons, Jr., asked the President what success he had had with the procedure of painting a ring of collodion on the glans penis in cases of eneuresis, saying that he had found it of considerable though temporary benefit.

The President said he had met with but little success with the use of collodion, and had abandoned it.

Dr. Rigdon said that none of the gentlemen speaking of eneuresis had mentioned electricity. Any irritation of the anus will sometimes cause retention of urine. One electrode is placed in the rectum, the other on the abdomen. A number have tried this method of treatment and with varying success.

Rotary Lateral Curvature of Spine.—**Dr. Emmet Rixford** exhibited a specimen of rotary lateral curviture of the spine, of extreme degree, found in the dissecting room.

REVIEWS AND NOTICES.

W. B. Saunders, the Philadelphia publisher, encouraged by the success of his "Question Compends," has decided to issue a series of hand-books or manuals in the various branches of medicine and surgery. These will be compactly and authoritatively written by representative authors. The mechanical work is proposed to be in the best style, and an effort will be made to make the series most popular by placing the price at the very low figure of $1.25 per volume.

OUTLINES OF OBSTETRICS; A Syllabus of Lectures Delivered at the Long Island College Hospital, by Charles Jewett, A.M., M.D., Professor of Obstetrics and Pediatrics in the College, and Obstetrician to the Hospital. Edited by Harold F. Jewett, M.D. Philadelphia: W. B. Saunders, 925 Walnut street. 1894.

In a prefatory note the author of this syllabus says that it is intended as an aid to the study of obstetrics in both the didactic and the clinical work of the college course. After careful examination and repeated consultation on mooted and important points, we have no hesitation in pronouncing it admirably adapted to its purpose. It is brief, and yet complete; concise, and yet lucid; logical, and yet not over-refined, and withal is comparatively free from those rhetorical—not to say grammatical—errors that so frequently mar American medical works.

WEEKLY ABSTRACT OF SANITARY REPORTS ISSUED BY THE SUPERVISING SURGEON-GENERAL MARINE HOSPITAL SERVICE. Vol. VIII. Nos. 1 to 52. Washington: Government Printing Office.

This volume comprises the weekly abstract of sanitary reports that have been issued during the year from the office of the Supervising Surgeon-General, Marine Hospital Service. Their usefulness has been greatly increased by the addition of a general index making them available for reference. These reports show that the department is doing good work, and the material presented is valuable for preservation, as well as for frequent reference for those interested in sanitary matters.

CLINICAL DIAGNOSIS. By Albert Abrams, M.D. (Heidelberg), Professor of Pathology, Cooper Medical College, San Francisco, Cal.; Pathologist to the City and County Hospital, San Francisco. Third edition, revised and enlarged. Illustrated. New York: E. B. Treat. pp. xii, 274. Price, $2.75.

Soon after the first appearance of this work, a second edition was demanded. This, in a great measure, corrected the defects of the original issue, and the book continued to find a ready sale. Its merits as a manual for students, and its certain popularity, attracted the firm of E. B. Treat, of New York, who effected arrangements with the author to take charge of its publication. As a result, the third edition is now before us. It has been revised with care, and has been enlarged in a manner that greatly increases its usefulness. The additional matter comprises a chapter on insanity in its relation to diagnosis, and a number of very valuable tables, comprising diseases of the brain and spinal cord, functional neuroses, the paralyses, and a table of the bacteria. We also find the use of drugs in diagnosis illustrated, and the volume closes with an enumeration of the newer methods of diagnosis, as reported in current literature. As we have already said, the book contains a vast amount of information; it is, in fact, a small encyclopedia of diagnosis. In its present improved and enlarged form, it will undoubtedly meet with an increased and well-deserved popularity. There is still need for improvement in the typographical arrangement of the book, so that it may present a more pleasing aspect. With the present arrangement of type this will be a difficult matter, but the effort should be made in future editions, as it would greatly add to its attractiveness.

FUNNY BONE; A BOOK OF MIRTH FOR DOCTORS, DRUGGISTS, DENTISTS, MEDICAL STUDENTS, AND OTHERS. The Funny Bone Publishing Company, St. Louis, Mo.

This volume of 102 pages, excluding advertisements, is of a decidedly unique character. The illustrations, the letter-press, and the humor, are all of a strictly professional shade. Much of it is very good, and, as might be expected, some is rather poor. The illustrations are uniformly good. The cover represents an elfish skeleton extracting from the ulnar nerve of a skeleton arm with a plex imeter, a shower of sparks or stars, probably the latter, as the new moon is conspicuous. Some of the jokes are old friends, but all are presented in an attractive garb and will be found interesting. The price is 50 cents and no one can fail to realize much more than that amount of "phun" out of it.

The International Medical Annual and Practitioner's Index, 1894 (Twelfth year). New York: E. B. Treat. pp. 620. Price, $2.75.

The publishers have headed their circular announcing the Annual for 1894, "Better than ever," and a careful perusal of the volume certainly bears out their statement. While the general style of the book has been maintained, its scope has been enlarged in several directions. One feature of increased value and importance is the presentation of a series of articles, necessarily brief, on the more prominent medical questions of the day in which there is a difference of opinion as to procedure. Excellent examples of this are the articles on appendicitis, written by an English and an American authority. In illustrations this volume far exceeds any of its predecessors. The article on insanity, by Dr. Shaw, presenting chromo-lithographs as well as a profusion of half-tone work, all of good character. We find but little to criticize. We must again object to the presence of advertisements in a book intended for sale to the profession. The article on new instruments, in its present shape, seems hardly worth including, and that on sanitary science might be enlarged with advantage. With these minor disadvantages we find additions and new features that more than balance the defects. Thus Dr. Koch's article on the new pharmacopeia is both timely and interesting, and Professor Hare's comments on therapeutic progress are, as usual, valuable. Altogether the Annual, which is larger and better than any previous issue, and which is still published at the same price, presents an excellent investment.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held April 5, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

Alfred Edward Blake. San Francisco; Missouri Med. Coll., Mo., March 27,'94.
John Sylvester Brown, New York; Med. Dept. Univ. City of New York, March 24,'91.
Frederick William Browning, San Francisco; Royal Coll. Phys. and Surgs., Edinburgh, Scotland, May 4,'88; Faculty Phys. and Surgs., Glasgow, Scotland, May 4,'88.
J. L. Carson, Alameda; Northwestern Med. Coll., St. Joseph, Mo., March 2,'94.
P. W. Easling, Burrton, Kansas; Coll. Phys. and Surgs. Keokuk, Ia., March 1,'81.
Williard H, Fales, San Francisco; Harvard Univ. School of Med., Mass., June 28,'82.
William J. Gavigan, San Francisco; Barnes Med. Coll., Mo., March 20,'94.
Robert Letcher Hogg. Paso Robles; Med. Dept. Univ. Louisville, Ky , Mar 13,'93.
David P. Kayner, Sacramento; Castleton Med. Coll., Vermont, Nov. 21,'49.
William Ross Lee, Los Angeles; Med. Dept. Univ. City of New York, March, 25,'90.
Archibald Lyle Macleish, Los Angeles; Univ. of Edinburgh, Scotland, M. B. and C. M., August 1,'81; Univ. of Edinburgh. Scotland, M. D., Aug. 1,'90
Bruce Miller, San Francisco; Coll. of Phys. and Surgs., Illinois, Feb. 23,'86.
Willard B. Pineo, Minneapolis, Minn.; Minnesota Hosp. Coll., Minn., Feb. 27,'85.
Henry D'Arcy Power, Sacramento; Lic. Society Apoth., England, July 5,'83.; Lic. Kings and Queens Coll. Phys., Ireland, March 12,'86.
J. W. Reeves, San José; Kentucky School of Med., Ky., June 30,'87.
William Benson Reeves, Los Angeles; Kentucky School of Med., Ky., June 30,'87.
Charles G. Reum, San Diego; Jefferson Med. Coll., Pa., May 2,'93.
A. B. Small, New York; Memphis Hosp. Med. Coll., Tenn., March 1,'88.
Dimitrius Staneff, Alameda; Cincinnatti Coll. Med. and Surg., O., March 22,'92.
Frederick R. Starr, Oakland: Harvard Univ. Med. School., Mass., June 29,'92.
A. W. Traverse, San Francisco; Rush Med. Coll., Ill., Feb. 19,'89.
William P. Williamson, San Francisco; McGill Univ., Montreal, Canada, April 1,'94.
Henry Baxter Wilson, Fresno; Tennessee Med. Coll., Tenn., March 17,'92.

The new Board met on Tuesday evening, May 1, and organized by electing A. H. Pratt of Oakland, President, and C. C. Wadsworth (present incumbent), Secretary and Treasurer.

At a meeting of the Board, held May 1, 1894, the following physicians were granted certificates:

Niven Agnew, Winnipeg, Manitoba; Univ. Victoria Coll. Coburg, Canada. Oct. 30,'58.
W. L. Bucklev, Stockton; Med. Dept. State Univ. Oregon, April 2,'94.
Thomas Cecil, San Francisco; Cincinnatti Coll. Med. and Surg., Ohio, March 6,'91.
David Andrew Conrad, San Francisco; Med. Dept. Univ. California, Dec. 14,'93.
August Bertram Cowan, Fresno; Cooper Med. Coll., California, Dec. 7,'93.
Wm D. Dilworth, Pasadena; Coll. Phys. and Surgs.;Chicago, Ill., April 3,'94.
F. X. Emerson, San Francisco; Cooper Med. Coll. California, Dec. 7,'94.
J. P. Frizell, Escondido; Kings and Queens Coll. Phys., Ireland, Aug. 1,'88.
Leonard K. Garfield, Algona, Ia.: Coll. Phys. and Surgs. Keokuk, Ia., June 18,'78.
Henry D. Grindle, San Diego; Med. Dept. Univ. City of New York, March 1,'67.
James Henry Haile, Benicia; Bellevue Hosp. Coll., N. Y., March 27,'93.
Albert M. Jones, Redlands; Med. Coll. of Ohio, March 10,'86.

Claude H. Kinnear, Covelo; Jefferson Med. Coll., Pa., April 3,'89.
Eleanor McAllister, Redlands; Syracuse Med. Coll., N. Y. June 13,'89.
Isaac E. Nicholson, Jr., Oakland; Bellevue Hosp. Coll., N. Y., March 26,'94.
T. Edward Post, Los Angeles; Coll. Med. Univ. Southern California, May 25,'92.
Emil Arnold Praeger, Los Angeles; Faculty Phys. and Surgs., Glasgow, Scotland, July 26,'83; Society of Apothecaries, England, Sept. 6,'83.
Walter Lee Price, San Francisco; Missouri Med. Coll., Mo , March 4,'90.
Wm. H. Prettie, Pasadena; Harvard Univ. Med. School, Mass., March 11,'68.
John B. Rosson, Tulare; Med. Coll. of Ohio, March 1,'72.
W. W. Stockwell, Stockton; Med. Dept. State Univ. Oregon, April 2,'94.
Geo. D. Taylor, Los Angeles; Leonard Med. Coll., North Carolina, March 27,'90.
Walter M. Thorne, San Francisco; Cooper Med. Coll., California, Dec. 7,'93.
Henry C. Wire, Los Angeles; Bellevue Hosp. Coll., N. Y., March 1,'66.

CHAS. C. WADSWORTH, Secretary,

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from April 20 to May 20, 1894.

Leave of absence for eight days, to take effect on or about May 15, 1894, is granted Captain Jefferson D. Poindexter, assistant surgeon, Fort Bowie, Arizona Territory. Par. 3, S. O. 21, Dept. of the Colorado, April 23, 1894.

First Lieutenant George M. Wells, assistant surgeon, will proceed from Fort Grant, Arizona Territory, to Fort Bowie, Arizona Territory, in time to reach the latter post not later than the 15th proximo, and report to the commanding officer for temporary duty during absence, on leave, of Captain Jefferson D. Poindexter, assistant surgeon. Upon completion of this duty, Assistant Surgeon Wells will rejoin his proper station. Par. 4, S. O. 21, Dept. of the Colorado, April 23, 1894.

The telegraphic instructions from these headquarters of the 17th instant, to the commanding officer, Fort Spokane, Wash., directing Captain E. C. Carter, assistant surgeon, to return to his station, Vancouver Barracks, Wash., are confirmed. Par. 6, S. O. 68, Dept. of the Columbia, April 30, 1894.

So much of S. O. No. 40, C. S., from these headquarters,'as relates to First Lieutenant Charles Willcox, assistant surgeon, is rescinded, and Captain Walter D. McCaw, assistant surgeon, now at the cavalry camp near Gilroy, California, is detailed in his stead to accompany Troop C, 4th Cavalry, as medical officer to the Yosemite National Park, California. Par. 5, S. O. 47, Dept. of California, May 3, 1894.

First Lieutenant George M. Wells, assistant surgeon, is detailed as additional member of the general court-martial appointed to meet at Fort Bowie, Arizona Territory, by Par. 5, S. O. No. 20, C. S., from these headquarters; this order to take effect and remain in force during Lieutenant Wells' temporary duty under Par. 4, S. O. No. 21, C. S., from these headquarters. Par. 4, S. O. 24, Dept. of the Colorado, May 5, 1894.

So much of Par. 1, S. O. No. 40, C. S., from these headquarters, as relates to First Lieutenant Charles E. B. Flagg, assistant surgeon, is so far modified as to direct him to report for duty at the cavalry camp near Gilroy, California, on the 16th intant instead of on June 1st. Par. 1, S. O. 48, Dept. of California, May 5, 1894.

Leave of absence for ten days, to take effect on or about the 26th instant, is granted Lieutenant Colonel J. V. D. Middleton, deputy surgeon general, U. S. army. Par. 2, S. O. 52, Dept. of California, May 15, 1894.

The leave of absence for twelve days granted Captain Louis A. LaGarde, assistant surgeon, by Par. 2, S. O. No. 22, C S., from these headquarters, is extended two days. Par. 1, S. O. 26, Dept. of the Colorado, May 15, 1894,

Leave of absence for four months, on surgeon's certificate of disability, is granted Major Van Buren Hubbard, surgeon.

Leave of absence for three months, on account of disability, with permission to leave the department of Texas, is granted Captain Alonzo R. Chapin, assistant surgeon.

First Lieutenant John S. Kulp, assistant surgeon, is relieved from duty at Fort Sheridan, Illinois, and ordered to Fort Spokane, Washington, for duty.

Captain C. N. Berkeley Macauley, assistant surgeon, is relieved from duty at the U. S. Military Academy, West Point, New York, and ordered to duty at Fort Wingate, N. M , relieving Major Washington Matthews, surgeon, who, on being thus relieved, will repair to Washington, D. C., and report in person to the surgeon general for temporary duty in his office.

So much of Par. 13, S. O. 79, A. G. O., April 3, 1894, as assigns Major Peter J. A. Cleary, surgeon, to duty at Fort Wingate, N. M., is revoked.

Captain William L. Kneedler, assistant surgeon, will, in addition to his present duties as post surgeon, Fort Mason, California, perform that of attending surgeon, San Francisco, California, until further orders.

Par. 2, S. O. No. 86, April 12, 1894, A. G. O. assigning First Lieutenant Harlan E. McVay, assistant surgeon, to station at Angel Island, California, is revoked He will be relieved from duty at Fort Huachuca, Arizona, and will report for duty at the Presidio of San Francisco, California, relieving First Lieutenant Charles Willcox, assistant surgeon, who, after being thus relieved, will report for duty at Angel Island, California.

ITEMS.

William R. Warner & Co., of Philadelphia, have added another to their long list of trophies by taking a silver medal at the recent International Medical Congress at Rome.

Dr. Emory Lanphear, editor of the *Kansas City Medical Index*, has resigned the chair of Operative Surgery and Clinical Surgery in the Kansas City Medical College, and has removed to St. Louis. He makes the change in order to become Professor of Surgery in the St. Louis College of Physicians and Surgeons.

Occidental Medical Times.

Vol. VIII. JULY, 1894. No. 7.

GANGRENE OF THE SCROTUM.

By E. E. Kelly, M.D., San Francisco, Cal.

Read before the California Academy of Medicine.

As a basis for my remarks and conclusions upon this subject, I wish to introduce the following case: On May 23, 1893, I was called to see Chas. Thomas, a bootblack, colored, aged 34 years; married, with a family of healthy-looking children; who gave the following history: Has always enjoyed good health. Has had the ordinary diseases of childhood. Denies all forms of venereal disease, and no evidence of syphilis is to be seen either upon himself or upon his children. A number of years ago he had a swelling and contraction of the left elbow, for which a resection was made. No other evidence of tuberculous disease was discovered, and no history of tuberculosis could be found among his relatives.

The first symptoms of the present trouble were noticed several days previous to my visit, when he observed some swelling of the prepuce, which prevented its retraction. The swelling rapidly extended, soon involving the integument of the entire penis and scrotum. The swelling was accompanied by slight itching and burning, and a dull pain, but not sufficient to cause any great inconvenience. About four days after the beginning of the swelling, the gangrenous process began, involving a small patch upon the inferior surface of the penis. From this point it rapidly spread to the scrotum.

I found my patient in the following condition: He was apparently a well-nourished individual, and yet had an anxious, hippocratic face. His temperature was 103° F.; pulse, 120, small and thready. For 48 hours he had had alternating chills and sweats. The house was permeated with the stench of decaying flesh. Upon examination, the scrotum was found to be a mass of gangrenous tissue. The lower surface of the penis displayed a large patch of denuded surface of irregular shape, extending back to the scrotum, from which the dead skin had fallen off. The urethra was uninvolved, and the patient had had no difficulty in urinating at any time. The scrotal tissue was entirely dead, and had separated from the integument and fascia covering the rami of the pubes and ischii and the perineal tissues behind.

With scissors I removed the sloughing mass without encountering any living tissue whatever. Beneath the mass of dead tissue, the connective tissue and tunica vaginalis covering the testes were black and gangrenous. When the sloughs were removed, as far as separation from the living structures beneath had taken place, the testes were entirely exposed, and also a large part of the spermatic cords dragged down by the weight of the unsupported organs. Some sloughing masses remained undetached; a charcoal dressing was applied, and a supportive treatment inaugurated.

After three or four days the sloughs separated entirely from the testes, leaving the white, fibrous tunica albuginea plainly visible. Not having before seen such extensive death of the tissues of this region, but remembering the rapid reparative processes of nature when a smaller surface was involved, I determined to wait and see what nature would accomplish in this case. The reparative process was most rapid and interesting. Using simply a dusting powder of sub-iodide of bismuth and a covering of iodoform gauze and absorbent cotton, frequently changed, I saw the "*vis medicatrix naturæ*" fashion and build a new covering for the denuded organs which could not be equaled by the most skilful surgical processes.

The testes were supported and held up near the body until a profuse growth of healthy granulation tissue, springing from the edges of the denuded surface, had grown up and around them, fixing them in this position. Remembering the elasticity of the integument of this region, as shown by the great elongation of the scrotum in neglected cases of inguinal hernia, I attempted to assist nature in the work of enclosing the exposed organs by drawing upon the surrounding skin with strips of adhesive plaster, but with indifferent results.

The reparative process was accomplished by the exuberant growth of granulations from around the edges of the denuded surface, drawing the skin along with them as they gradually surrounded the testes, so that a very small surface was left to be covered by cicatricial tissue, as I hope to show you by the patient's present condition.

The integument of the penis reformed rapidly, but shows far more cicatricial tissue than is present on the scrotum. The cicatricial tissue is devoid of pigment, a not unusual result to be seen in scar tissue of the negro race. In seven weeks from my first visit, the repair was complete.

Gangrene of the scrotum is by no means of rare occurrence. The genital region of the body in both the male and female is frequently the seat of such processes. The anatomical character of the penis and scrotum, especially the latter, makes strangulation of its tissues easily possible. The scrotum consists of simply the skin and the superficial fascia, which is a continuation of the fascia of the perineum, groin and inner sides of the thighs. It is connected by a very loose, areolar tissue to the tissues beneath, and is freely movable over them. In other portions of the body the skin and superficial fascia is intimately connected with the deeper structures, and frequent capillary vessels pass back and forth from skin to fascia. In the scrotum those inosculating capillaries are not found. All the vessels are long and tortuous, and while very numerous, having frequent anastomosing branches with each other, have no connection with the arteries of the deeper structures. Therefore, when the scrotum becomes edematous, the serum pressing upon these vessels is quite likely to occasion strangulation and death of the tissues.

This region, also, in those not scrupulously cleanly in their habits, affords a most favorable field for the lodgment and development of various microbic organisms, ready to invade the tissues when the minutest door for infection opens to them. Infiltration of urine in this region not infrequently occasions extensive destruction of tissues. Erysipelas may be followed by gangrene, and it is quite probable that some so-called cases of idiopathic gangrene may result from this cause. Dr. Allen, of New York, suggests that the streptococcus may in some cases produce simply erysipelas, and in others—where there is lowered vitality, or in tissues with lower resistance, or where for any reason the pathogenic power of the streptococcus is increased—a gangrenous process.

Diabetes seems to lower the vitality of the entire organism, rendering its resistance to diseases much less effective, and gangrene of the scrotum or other parts of the body is not infrequently seen as a result of this disease. Thrombosis and embolism are given as causes of gangrene of the scrotum. But such cases must be of limited extent, since the scrotum receives its blood supply from so many sources, and anastomosis is so free between them that the collateral circulation would be quickly established unless the thrombus or embolus should involve the common iliac artery or the several arteries supplying the scrotum.

The acarus, itch-mite, and the pediculus pubis have each been assigned etiological relationship to gangrene of the scrotum, but I am inclined to think that very few authorities, in these days of bacteriological research, will admit any direct relationship between the parasites and the gangrenous process. However, the presence of these itch-mites may open a highway of infection for specific microbes into the lymphatic channels through the scratching nails of the victims.

The rapid advance in recent years of bacteriology and microscopy threatens to greatly weaken, if not to destroy, one of our time-honored refuges when, from lack of knowledge of an adequate cause, we learnedly call the condition an "idiopathic" one. It seems to me quite probable that what we have been accustomed to style idiopathic gangrene of the scrotum will ultimately prove to be microbic in origin.

Unfortunately, owing to the late stage of the disease in this case when first observed, no bacteriological investigations were made, and therefore no definite conclusions can be arrived at. However, in the absence of any other discoverable pathological factor, I am inclined to believe that microbic infection occurred through some unnoticed lesion at the point where the swelling first began.

In my search for literature on this subject, I have been unable to find any large number of cases, and in most of those reported there have been open lesions in the groin or vicinity, or some constitutional dyscrasia—as diabetes or alcoholism. In conversations with surgeons of this city I have met with equally poor results, and they affirm that such cases as the one detailed in this paper are exceedingly rare. Dr. L. C. Lane says he has seen but one case on this coast, but that he had seen several in Paris.

Dr. Alexander Marcy, of Baltimore, reports a case in a child two weeks old, where sloughing of the scrotum and part of the skin of the penis occurred. As in the case I have reported, the lesion began in edema of the penis and rapidly extended to the scrotum, followed by gangrene of the entire scrotal sac. Rapid and complete recovery occurred. He expressed no opinion as to the etiology of the case.

Dr. Platt, of Baltimore, in the *Medical News*, reported three cases where gangrenous patches appeared on the scrotum after operation for the removal of inguinal glands. In all of these cases the sloughing involved the side of the scrotum corresponding to that from which the glands were removed, and not involving the opposite side. In all of the cases, a bridge of healthy skin separated the sloughing surface from the operated field. Hence he concludes that the gangrene was of neurotic origin, resulting from injury to the trophic nerves through the operation in the groin, since the nervous supply is the same to the lymphatics of the groin and to the scrotum. He arrives at his conclusions by exclusion: excluding septic gravitation, from the fact that the currents in the lymph channels are toward the body; strangulation of the blood supply was excluded, from the numerous arterial branches extending to the scrotum, remote from the field of operation. There was no evidence of erysipelas at the site of operation and the sloughing did not involve any tissues contiguous to it. In support of the theory of neurotic origin, he refers to other reflex phenomena of the skin, as various forms of herpes and in the symmetrical gangrene of Reynaud's disease.

Dr. Abbé, of New York, reports several cases of sloughing of the ischio-rectal fossa, in a paper entitled "An Idiopathic Gangrenous Cellulitis Around the Rectum." He expresses his opinion that the cases were of septic origin.

The most recent case reported is one by Dr. C. W. Allen, before the New York Academy of Medicine, January 9, 1894. The subject, an oyster-man, 34 years old, was admitted to the City Hospital March 15, 1893. In this case there was a suppurating bubo in the groin. The patient was intoxicated when he first noticed the dull pain and swelling of the scrotum. In four days the swelling became gangrenous and left both the testicles exposed. As in my own case, he left the healing process to nature and dismissed the patient entirely cured in six weeks from the time of his admission. He concludes that alcoholic excesses, an indefinite history of violence, and the open wound were probably important etiological factors in his case.

The treatment in these cases should always be a conservative one. The first impulse of the surgeon, upon seeing the testicles entirely denuded, is to remove them, as it seems quite impossible that they can be enclosed with a covering of skin without the presence of so much scar tissue as to make unnatural pressure upon them and to render them useless. But from the history of all these cases in which nature provided for the exposed organs, I conclude that in no case is removal justifiable so long as the testicles are not included in the gangrenous process. It must be remembered that however urgent the need of castration, and however rapid the cure, the patient never forgives the surgeon who unsexes him. Some simple antiseptic dusting powder and a due regard for cleanliness are the only measures needed, unless the granulating tissue becomes unhealthy. If any constitutional dyscrasia be present, such as diabetes, it, of course, should be carefully attended to, and supportive measures used to build up the general health.

In conclusion, let me say that from the clinical side alone it would seem not improbable that the gangrenous process in the scrotum, when not due to constitutional dyscrasia, is infectious in origin, since in all but two of the reported cases I have mentioned, an open channel of infection is recorded, and it is not improbable that in these two some unnoticed door of infection was open to the microscopic germs.

1247 Market street.

CATARRHAL PNEUMONIA IN CHILDREN, WITH REFERENCE TO A SPECIAL METHOD OF TREATMENT.

By F. B. SUTLIFF, M.D., Sacramento, Cal.

Read before the Sacramento Society for Medical Improvement.

While there are few diseases with which the general practitioner may not come in contact at any time, there are some that he can regard as belonging to the season of the year. The fall and summer months accompanied by fevers and bowel diseases, while winter brings pneumonia and bronchitis in their different forms; and, of late, influenza. Of all the forms of pneumonia with which we have to deal—and all are serious—I think none is calculated to give the practitioner more concern, nor to cause the friends more alarm, than that form so often seen in young children and old people—broncho-pneumonia.

There seems to be some confusion in giving to the condition a name that will suit the symptoms. Gordon Morrill, in Keating's Cyclopedia of Diseases of Children, when trying to give a definition, speaks of it as "acute broncho-pneumonia, acute lobular pneumonia, and others which are obsolete." Osler says that much of this confusion has arisen from the description of capillary bronchitis as a separate disease, "whereas it is only a part, though a primary and important one, of broncho-pneumonia."

We all are perfectly familiar with the clinical picture of the disease. We are generally told that the child "has a cold on the chest;" that it has been ill for a day or two, that home remedies have been given without effect, and the mother has become alarmed because of the fever and other symptoms of distress. We find the patient with all the symptoms the mother speaks of, and more. The pulse may be very rapid, the respiration proportionately increased, fever high, and the eyes often having nearly the expression that we see in croup. Upon auscultation, the trouble is often found to have extended over a large area of both lungs, though I have seen cases where only one was affected. Marked dulness is not found upon percussion, at least in the beginning of an attack, though it can often be discovered in spots. Later on it may become general, and this can well be understood when we reflect that the condition may be such as one author, Morrill, describes. He says "in severe cases every component part of the lung may become implicated by the inflammatory process, which assumes in each part the form proper to the tissue affected."

Osler says that "the disease is, as a rule, a secondary affection, often coming on after scarlet fever, whooping cough, or measles, and less often following smallpox, erysipelas and typhoid fever." I think that the greater number of cases met with in this locality are primary, though it is surely to be dreaded as a complication of the diseases mentioned. Morrill claims that climate is an important factor, and lays a deal of blame to sudden changes. This fact is borne out in our own locality, as it is in the season of wet and changeable weather that we meet with most cases. He says it is during the period of dentition that the disease occurs with the greatest frequency and is attended with the greatest fatality. This he claims is due to the fact that "the bronchial and respiratory epithelium is of greater size during this period; to its irritability, the ease with which it is proliferated and shed, and the fact that inflammation in children is apt to be of the embryonal type. As the lung develops, the disease is less frequent and fatal." This is proven by records of autopsies, and he gives tables to support his position.

He further states that no germ peculiar to the disease has so far been discovered, and that the history of the disease, as to lack of contagion, is such as to lead to the belief that there is none. No one has observed a house to house contamination, as is often seen in croupous pneumonia. He thinks the inflammation due to numerous causes, and that it is transmitted to the bronchial mucous membrane. Northrup says that children who are confined to bed for a long time are very prone to contract the disease in a low, insidious form. Hypostatic congestion of the lungs and the collection of bacteria in the mouth favor it. I think that we can all agree with him when he says that it is often the scrofulous child, one that is poorly nourished, and whose surroundings are not of the best, that contracts the disease, though this is by no means always the case. I have seen it in the best as well as in the poorest homes, but not so often.

Nathan S. Davis says the disease may arise from all the causes that are capable of exciting inflammation in the lungs and medium-sized tubes. That the temperature seldom rises beyond 103° F., unless the disease is complicated with lobular pneumonia; that the urine, as in other forms of pneumonia, is deficient in chlorine salts. The late S. O. Vanderpool, of New York, was in the habit, years ago, of teaching that frequent examinations of the urine should be made during an attack of pneumonia, as by a return of the chlorides the practitioner might be assured of a prompt change in the disease for the better, and so, often declare it before it could be seen by others. Davis says, further, that if the disease continues beyond the third or fourth week it is prone to become chronic, to continue indefinitely, and that a prolonged attack seems to cause a susceptibility to the disease which recurs again and again.

Pepper says, after stating the causes already given: "Finally, there are many persons who possess a catarrhal diathesis; that is, in whom the epithelial layers are especially vulnerable, and when attacked are especially prone to take on cellular proliferation of a deep-seated and obstinate character." All authors mention the fact that the disease may result in pulmonary phthisis. Pepper describes a very interesting case in a young man, 23 years of age, whose attack was followed by gangrene of the lungs, and as a result there were frequent attacks of hemoptysis. He was in bed four weeks.

We have all seen how severely the nervous system may suffer from the effects of the disease, convulsions in children and delirium in young people being by no means uncommon. All writers admit the gravity of the disease, and no practitioner can fail to appreciate the danger it brings, especially to the very young, the feeble and the aged. In view of this fact its treatment becomes of very great importance.

Osler recommends a purge of castor oil or calomel, a jacket of cotton wool, opium for pain and restlessness, good food, brandy; if the pulse should show signs of failing, stimulating expectorants, such as ammonia, squill and senega. For children he prefers the aromatic spirits of ammonia to the carbonate. He says if the tubes fill too much with mucus, emetics should be given, either the wine of ipecacuanha or, if necessary, tartar emetic. In threatened collapse he recommends strychnin, electricity, the hot and cold douche, and inhalations of oxygen.

Pepper says that there is a deal of good in all this, but argues that the greatest attention should be given to the digestive functions. That not only the diet but the whole plan of medication should be laid out with the view of not disturbing that powerful ally, the stomach. He claims that there is, as shown by the tongue, a catarrhal condition, not only of the bronchi, but of the whole gastro-intestinal tract. He therefore restricts the diet in the early stage, and gives, if called for, quinine by enema, so as not to disturb the stomach. He speaks of the good effect where opium cannot, for any reason, be given, of hyoscyamin, in doses of $\frac{1}{100}$ to $\frac{1}{50}$ of a grain for an adult.

Gordon says that "the time-honored flaxseed poultice should not be used," but recommends the cotton jacket instead. He gives opium at first, to ease the harrassing cough that so disturbs the patient, but advises caution later on, "lest that sensibility that prompts the child to expel mucus by cough be blunted." He says he is aware that good authorities prohibit its use in any and all stages of the disease, but he feels that it is a valuable remedy to give the patient rest, thereby saving strength, which it will so greatly need later on.

Flint recommends emetics and opium in the early stage of the disease. He leaves, as he does in nearly all that he says about the treatment of diseases, a deal to the good sense of the attending physician, and very properly so, for this is a disease where one must have resources and use them.

In writing this paper my object has been to recommend to your attention a plan of treatment that I think is as nearly a specific as we generally—I think I ought to say, *ever* get in medicine. I know that Dunglison says that probably no such thing as a specific exists, and he is doubtless correct, but by a specific I mean a form of medication that is as likely to lead speedily to satisfactory results as mercury in syphilis, or quinine in malaria. I think there is no remedy that is more of a specific, for any disease, than is veratrum viride in catarrhal pneumonia in children. During the past five years I have used little else in these cases, and in the next five years I expect to find no better treatment.

In years gone by, I was in the habit of using aconite and belladonna, I often thought with good effect, but I have discarded *them* wholly. I do not believe veratrum has anything like the same influence on other forms of pneumonia, and I think to this is probably due the fact that it has at times received such unlimited praise, and at others, such condemnation. I give the tincture in not large, but oft repeated doses, until the pulse is reduced, the respirations lowered, and the whole aspect of the case changed for the better.

I do not hesitate to give it to young, nursing babes, prescribing it in doses from a fraction of a minim to more for older patients, and repeating the dose at least each two or three hours. Dr. W. A. Briggs first called my attention to the remedy for this peculiar condition, and during the past four or five years I have treated many cases with it, and have seen him use it with very satisfactory results.

I shall briefly report the last really grave case in which I used it:

I was called to see a child aged 2 years. I found him breathing about sixty to the minute, pulse very fast. He could not sleep nor rest for the constant cough. He had been ill for one night only, but there were course rales over both lungs. He was getting blue, and the case looked like a bad one. All the worse because of the fact that the family know nothing about nursing or caring for the sick. I was fearful about giving veratrum; I thought the safest thing to do was to stimulate, and digitalis seemed to be more appropriate for such a case. I told the family that I was afraid the little one would die, and requested consultation. Dr. W. A. Briggs was called and advised giving half minim doses of the tincture of veratrum with sweet spirits of niter in syrup of yerba santa, the dose to be repeated hourly. In a few hours its good effect was manifest; in twelve hours the child was very much better, and the next day it had changed to an ordinary case and soon went on to convalescence.

In looking over a few authorities to see if any mentioned the drug in this connection, I find that it is oftener condemned than otherwise. A writer in the United States Dispensatory says: "The patient would usually be better off without it, or the drugs that are combined with it; it only masks or hides the symptoms, and does not cure them." In reply to this, I can only bring a long list of cases where the drug has done all that a drug can do in any disease. I admit that I often combine it with other things, but the remedy is not less satisfactory if I prescribe it, as I often do, from my pocket case with water only.

212 J street.

THE CAUSES OF FREQUENT AND PAINFUL URINATION.

By R. L. Rigdon, M.D.

Read before the San Francisco Medico-Chirurgical Society.

The formation of urine is a continuous process. When taken from the blood it becomes at once a foreign body, so far as its influence upon the general system is concerned, and must be eliminated. Instead of providing for a continuous discharge of this fluid from the body, by means of a direct tube, nature has interposed a half-way station, so to speak, in which the urine collects and in which it remains until permitted to complete its journey. Ordinarily evacuation occurs from four to six times in the 24 hours. The recurrence of this event has been regulated by habit until it adapts itself to the circumstances in which the individual is placed and is conformed to his convenience. Should circumstances not be suitable, the act can be delayed a considerable time, or until the surroundings are more propitious.

Unfortunately, disturbances of the urinary system are quite common, and since this is such a vital portion of the economy, any alteration in its physiological processes is immediately felt. There are many symptoms connected with disease of this system to which the attention of the surgeon will be directed. Some are of minor, some of greater importance. The two following are, perhaps, the ones most frequently encountered: (1) Frequent urination, and (2) painful urination. These symptoms are so frequently present, are so distressing, and often so persistent in spite of treatment, that we will be warranted in spending a short time in their discussion.

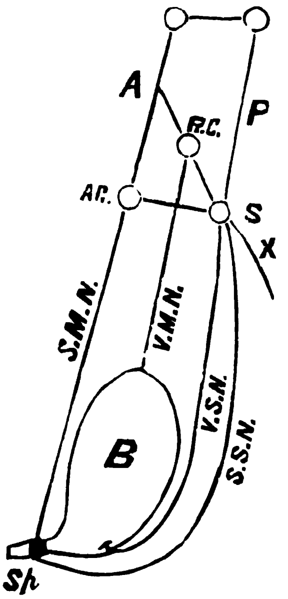
In order to appreciate the various relations of these symptoms, it is first necessary to investigate the act of normal urination.

The bladder is made up of a layer of mucous membrane continuous with that of the ureters, pelvis of the kidneys, and the urethra resting upon a sac-like arrangement of involuntary muscular fibers. These fibers are disposed in two principal layers, longitudinal and circular. At the neck of the bladder these latter are most numerous, forming a circular band known as the internal vesical sphincter. The longitudinal fibers are found, for the most part, on the anterior and posterior surfaces of the bladder, and are collectively known as the detrusor muscle. The peritoneum forms a partial serous covering. The prostate surrounds the first part of the urethra, and is largely made up of circularly and longitudinally disposed involuntary muscle fibers. In the apex is found a layer of striped muscle entirely surrounding the urethra.

Immediately beneath the mucous membrane of this portion of the urethra, as well as the membranous, is found a layer of involuntary muscle, continuous with the circular layer of the bladder. The compressor urethræ muscle is under the control of the will, and surrounds the membranous urethra from the prostate to the anterior layer of the triangular ligament. The accelerator urinæ is so disposed that its contractions compress the bulb of the urethra and aid in the expulsion of the last drops of urine. It is also under the control of the will. The remaining perineal muscles, and also the abdominal muscles, are more or less employed in urination, but the ones mentioned are those directly concerned.

The nerve supply to these muscles is from two sources, the spinal and the sympathetic. Parts of the second, third and fourth anterior sacral nerves unite with branches from the sacral sympathetic ganglia and from the pelvic plexus. From this plexus branches are sent along the vesical arteries to the bladder; other branches are distributed to the prostate and urethra. The influence of lesions of the spinal cord upon micturition would seem to indicate that the prostate and penis receive additional innervation through the splanchnic nerves. The perineal muscles are supplied by the pudic nerve. The mucous membrane lining the bladder and urethra is supplied by sensory filaments.

In normal urination, as the urine trickles into the bladder from the ureters, that viscus becomes gradually distended until sufficient pressure is exerted upon the sensory nerve filaments to arouse them to physiological action. This impression is conveyed to the cord and is there translated into a motor impulse that is sent to the bladder, causing it to contract and thus expel its contents. This is true of the act during infancy, when the sphincters are but little used, but, as the child grows, is influenced more and more by training, and the will begins to be better developed, the different steps in the process become more complicated. The impression that is first conveyed to the cord is reflected to the bladder as before, but the contraction aroused is not of sufficient force to evacuate the urine. As the distension of the bladder becomes greater, more pressure is exerted upon the nerve filaments and the sensations aroused and conveyed to the cord are more intense until, at last, they are of sufficient force to reach the brain, and a conscious desire to urinate is aroused. Through the influence of the brain the vesical contractions are increased, the sphincters are inhibited from acting, and the urine is expelled. These different steps will be better understood by reference to the accompanying diagram:



B—Bladder.
S—Sensory center in cord.
R. C —Reflex center in cord.
A. C.—Automatic center in cord.
Sp—Sphincter.
V. S. N.—Vesical sensory nerve.
V. M. N.—Vesical motor nerve.
S. S. N.—Sphincter sensory nerve.
S. M. N.—Sphincter motor nerve.
X—Sensory nerve, general system.
P.—Sensory nerve to brain.

The irritation first induced in the sensory nerve endings in the bladder mucous membrane is conveyed through V. S. N. to S.; from there to R. C., where it is transformed into the motor impulse, which passes, by means of V. M. N., to the bladder, resulting in contraction. This is all that is required in the infant, but later the mechanism is more complex, and the steps may be explained thus: The first impressions taken to the sensory center in the cord are reflected to the bladder as before, but the contractions are too feeble to overcome the resistance offered by the sphincters, that are now better developed, and consequently more powerful. More intense impressions through V. S. N., caused by greater distension of the bladder, are finally referred to the brain through P, and a conscious desire to urinate is aroused. Should it be convenient at this time to complete the act, motor impulses are sent through A to the mechanism in the cord presiding over micturition. R. C. is stimulated to greater activity; A. C. is inhibited from maintaining the contraction of the sphincter, the expulsive force upon the urine is greater, the resistance to its exit is less, and the act is satisfactorily accomplished.

Should it be desired to retain the urine for a longer time, instead of the brain inhibiting A. C. that center is stimulated to greater activity, thus strengthing the contractions of the sphincter and increasing the resistance to the outflow of urine. The entrance of a few drops into the prostatic urethra gives rise to a more intense desire to urinate, and it may be that consciousness of the condition is in this way aroused. The contractions of the bladder are also made stronger by reflexes from this part of the urethra. Usually the abdominal muscles are brought into action and the force thus employed aids in impelling the first drops into the urethra.

By referring to the diagram and remembering what has been said, we can easily sum up the general causes that produce frequent urination.

(*a*) Any condition that will bring about increased irritability of the vesical mucous membrane, as inflammation, congestion, neuralgia, drugs, etc. As the urine enters the bladder it comes in contact with a membrane that is hyperesthetic—more ready to respond to stimulation. A less degree of distension is required to set in motion the reflex phenomena, and consequently the act is more frequently repeated.

(*b*) Abnormally irritating contents of the bladder. Given a mucous membrane that is normal, and unusually irritating contents will stimulate the nerve endings and will result in increased contraction and frequent evacuations. It has been determined that the bladder will retain more of normal urine than of any other fluid, consequently any deviation will render it more irritating. This is seen in hyperacidity or the reverse condition, alkalinity; also, in those pathological states in which pus or blood, or other foreign material, is present in solution. Under this heading must also be classed foreign bodies, calculi, for these unduly stimulate the sensory nerve endings.

(*c*) Increased secretion of urine. Let the bladder be normal and its reflex arc intact and frequent urination may arise, because of an abnormally rapid filling of the viscus, as in diabetes, hysteria, and in diminished elimination of fluid through the integument. This is readily understood. Whenever the bladder contains a certain amount of urine, or reaches a certain degree of distension, micturition occurs. If the bladder refills rapidly the required distension will be soon reached and early evacuation recur.

(*d*) Diminished capacity. The capacity of the bladder may be diminished to such a degree that a small amount of urine will produce sufficient distension to bring about contraction strong enough to cause evacuation. This arises in concentric hypertrophy or tumors within the bladder, or pressing upon it from without. Residual urine will also diminish the working capacity.

(*e*) Irritability of the vesical center. Any condition that will produce an undue irritability of the vesical centers in the cord or brain may give rise to the symptoms we are considering. This is rarely seen as a primary lesion, but is usually secondary to some peripheral disturbance.

(*f*) Reflex influences. Many cases of frequent urination will fall under this head. The sacral plexus which supplies the bladder also innervates the urethra, rectum, perineum, and other parts far removed. Implication of any of these branches may manifest itself in disordered micturition. Kidney disease is an example; so, also, is urethral stricture, phimosis and balanitis. A proper appreciation of this fact will frequently enable the surgeon to give relief when otherwise treatment might be almost futile.

(*g*) Mental impressions, as fear, anger. Mental labor, that is associated with worry are prone to produce frequent urination. This is seen in those engaged in hazardous business enterprises where large amounts are at stake.

(*h*) Paresis of the vesical sphincter. The lesion causing this paresis may be either central or peripheral. Tumors, cerebral embolus, tabes dorsalis, are examples of the former. The latter is due to impairment of the sphincter motor nerves. In either case the faulty action arises from disturbances in the reflex arc.

It will be observed that many of these specific causes act in more than one way. Residual urine will not only give rise to this symptom by diminishing the capacity of the bladder, but the decomposition that occurs in it will light up an inflammatory reaction and thus render the nerve filaments unusually susceptible to irritation.

Many of the conditions that give rise to frequent urination will also produce painful urination. In following out the plan of this paper it may be necessary to repeat what has already been said.

The general causes of dysuria may be grouped as follows: (1) Hyperesthesia of the mucous membrane of the bladder and urethra. (2) Abnormal urine. (3) Foreign bodies in the urinary tract. (4) Pressure upon adjacent inflamed parts. (5) Reflexes from nerve-related parts. (6) Implication of the nerve centers.

Under the first heading, hyperesthesia of the mucous membrane, we make two subdivisions (*a*) that of the bladder; (*b*) that of the urethra. The first may be caused by inflammation, either simple, specific or tubercular, congestion, neuralgia, ulcers, fissures, tumors, and prostatic hypertrophy. In simple or gonorrheal inflammation the pain will appear promptly with the onset of the disease, and will be in proportion to its intensity. In general inflammation the pain will be greatest at the beginning of the act; *i. e.*, when the bladder is most distended and the sensory nerves most strongly pressed upon. If the inflammation is localized at the vesical neck, the pain will be most intense at the termination of the act when the contracted muscle grasps the sensitive membrane. In tubercular inflammation the manner of invasion will have much to do with the production of pain. If the mucous membrane is first attacked this symptom will be present, as in the varieties just described. Should the invasion come through the serous covering, or in the muscular coat, grave changes in these structures may take place before sensory disturbances are noticed. Neuralgia is often irregular in its appearance, and transitory in duration. While it may occur at any time during the act, it is more often felt at the beginning. In many cases but little pain is associated with hypertrophy of the prostate. It is only when the enlargement has attained sufficient size, or is so situated as to interfere with the outflow of the stream or the complete emptying of the bladder, that sensory disturbances are acutely felt. In these cases the pain is usually due to the secondary inflammatory changes that occur. Tumors will give rise to painful urination, chiefly as they are associated with inflammatory changes in the mucous membrane. Ulcers and fissures produce continuous pain, but it is augmented by contraction of the bladder.

(*b*) Abnormal urine. There is a physiological variation in the density and reaction of the urine, but when it passes beyond a certain point in either of these directions it becomes an irritating substance. In some deranged conditions of the general system some of the normal solids of the urine may be relatively increased or diminished, or unusual substances filtered from the blood by the kidneys. Examples of this condition are oxaluria, lithuria, concentrated urine. Pus or blood in solution in the urine may so alter its character as to render the bladder intolerant of its presence. Many drugs, as turpentine and cantharides, that have a selective action upon the pelvic viscera, including the genito-urinary apparatus, are removed from the general circulation by the kidneys, and may render the urine extremely irritating.

(*c*) Foreign bodies. That foreign bodies in the bladder or urethra will cause painful urination needs no explanation, their *modus operandi* is plain. They may be divided into two general classes—those formed within the body and those introduced from without. Under the first variety will be classed the various examples of calculi and gravel, and the vesicles and hooklets of kidney hydatids. Under the second may be grouped a large number of articles, as glass, needles, pieces of sticks, broken catheters. One patient, who came to the clinic last year, had lost in his bladder a pencil of fat pork, six or eight inches long, with a string attached. He suffered most intense pain prior to its removal.

(*d*) Pressure upon adjacent inflammations. Painful urination may arise from pressure of a distended bladder or urethra upon adjacent inflamed parts. Sometimes a vesicula seminale is the seat of inflammation. As the bladder fills and presses more and more upon it, much discomfort is produced. The pain is relieved after the bladder is emptied. It is well to bear this in mind, as the lesion is easily overlooked. Pressure upon a prostatic or perineal abscess may also cause dysuria.

(*e*) The sensory disturbances that are felt in the bladder and urethra are not always produced by disease of these structures. Both may be entirely normal, and the disturbance referred to them from adjacent parts that are the seat of the disease. Thus, nephritic calculus, tuberculosis, and pyonephrosis may in a reflex manner give rise to painful urination. This may also be said of phimosis, or balanitis, or a morbid condition of the rectum, or anus, or other nerve-related part.

(*f*) Affections of cerebral or spinal centers. The exact situation of the centers of urination, both in the cord and brain, has not been accurately determined. Electrical stimulation of certain parts of the central nervous system produces evacuation of the bladder. A hemorrhage or tumor in the cord or brain may be the cause of both frequent and painful urination. This is true also of an embolus.

Causes of Frequent Urination.
- Hyperesthesia of vesical nerve terminals
  - Inflammation.
  - Congestion.
  - Neuralgia.
  - Drugs.
- Abnormally irritating contents
  - Alteration in character of urine.
  - Additions to urine
    - Pus.
    - Blood.
  - Foreign bodies.
  - Polyuria.
  - Hysteria.
  - Check to perspiration.
- Diminished capacity of bladder
  - Concentric hypertrophy.
  - Tumors.
  - Residual urine.
- Irritability of vesical centers
  - Tumors.
  - Excessive venery.
- Reflex influences
  - Local
    - Stricture.
    - Kidney diseases, etc.
  - General.
- Mental impressions.
- Paresis of vesical sphincter
  - Central
    - Tumor.
    - Embolus.
    - Tabes dorsalis.
  - Peripheral
    - Impairment of motor nerve to sphincter.

Causes of Painful Urination.
- Hyperesthesia of M. M.
  - Bladder
    - Inflammation.
    - Congestion.
    - Neuralgia.
    - Tumors.
    - Ulcers or fissures.
    - Prostatic hypertrophy.
  - Urethra
    - Inflammation.
    - Neuralgia.
    - Ulcer or fissure.
- Abnormal urine
  - Concentrated.
  - Highly acid or alkaline.
  - Oxaluria.
  - Lithuria.
  - Pyuria.
  - Drugs.
- Foreign bodies in bladder
  - Formed within
    - Stone.
    - Gravel.
    - Vesicles of kidney hydatids.
  - Introduced from without
    - Glass.
    - Needles.
    - Bougies, etc.
- Pressure upon adjacent inflammations
  - Seminal vesicles.
  - Perineum.
- Reflex
  - Kidney
    - Pyonephrosis.
    - Calculus.
    - Tuberculosis.
  - Phimosis or balanitis.
  - Rectum, anus, or other nerve-related parts.
- Affections of cerebral or spinal centers.

The foregoing diagrams will give schematic outlines of the cause of both frequent and painful micturition. Each one of the subdivisions is itself worthy of a separate paper.

Nucleus Building.

ABORTION; ITS CAUSES AND TREATMENT.

By W. R. Cleaveland, M.D., Biggs, Cal.

Read before the California Northern District Medical Society.

By abortion I mean the premature expulsion of the ovum, and in speaking of its causes I shall not regard the purely arbitrary division into abortion, miscarriage and premature delivery, according to the period in which it occurs.

The causes of abortion are predisposing and exciting. Of the predisposing causes there are certain systemic conditions, that result in the death of the fetus, as excessively high temperature in febrile conditions, the transmission of the poison of infectious diseases from the mother; eclampsia, or the condition which causes it, may result in the death of the fetus, as may also extreme anemia, the result of hemorrhage or disease. The fetus may die in consequence of disease of its appendages, as in syphilitic degeneration of the villi of the chorion; or it may die as the result of violence, direct or indirect; consecutive changes taking place in the appendages, when it is thrown off sooner or later. Certain states of the uterus act as predisposing causes, as endometritis, perimetritis, and their results. Displacements, tumors, or old and extensive adhesions, that prevent the natural expansion of the uterine walls, may also be included under this head. There is a class of women, in whom no disease of the ovum or of the genitalia can be discovered, who abort, and, in the absence of a patent cause, this has been attributed to a peculiar condition of the nervous system.

Once a predisposition exists, anything that produces an increased flow of blood to the pelvic organs may excite contractions. Emotion is a frequent cause. When no predisposing cause exists it is remarkable—it is almost marvelous—the violence, indirect as well as direct and mechanical, the uterus will bear without a sign of contraction.

The fetus having perished, the uterus may carry its contents, in the absence of an exciting cause, for a longer or shorter period, sometimes for several months, as is illustrated by the following case:

April 30, 1878, I was called to see Mrs. J. H——. She was suffering from nausea, which, she attributed to pregnancy. She had passed two months without menstruation; at the end of the second month nausea came on. It was for the relief of this nausea that I was called, and, prescribing, I heard nothing more from her until the latter part of September following, when, one Monday morning, her husband came for me in great haste. Upon reaching my patient, I learned that on the second day of May she commenced, as she thought, to menstruate again. The nausea was then completely relieved, but a slight color had kept up every day, from that time.

The flow was less than is usual in menstruation, and, so far from weakening her, she had felt better and stronger than for years before, and had worked hard all summer. This Monday morning she was taken with flooding when at the wash-tub. Examination revealed an enlarged uterus, the cervix hard, os somewhat dilated, and a slight oozing going on. The cervix was not dilatable. She had never felt motion, and since the second day of May had not thought that she was pregnant. She was certain that no fetus had passed, and her word could be relied on.

I was confident that she was pregnant, and at about the end of the second month, when I saw her on the 30th of April. That would make it about the end of the seventh month, and the uterus was not large enough for that period, and yet was much too large to suppose that it contained only the remains of a two-months' pregnancy. I tamponed, gave ergot, and next morning met a medical friend in the case who wished the sound passed.

It entered two and one half inches, when it impinged upon something which gave the impression of being solid. The external hand felt the upward pressure of the sound *in utero*. We agreed that the uterus probably contained the relics of a pregnancy, and he advised that the treatment be continued until the cervix softened. On the tenth day I found that she had been having some pain the latter part of the previous night. Introducing the index finger through the cervix, which now could readily be done, pains came on and soon expelled the fetal sack, with its contents, a two-months' fetus in a mummified condition. The placenta came away after some pretty strong pains. I have seen smaller placentæ at full term. It was hardened and almost dry. This explained why the sound only entered two and one-half inches. The placenta was attached at the fundus, and the sound probably reached it. In its dry and hardened condition it gave the impression of a solid substance. Recovery was prompt, but my patient did not have the same sense of vigor that she had during the time she was carrying this fetus and placenta, although no sub-involution or other genital affection was left behind. She often assured me that she had enjoyed a degree of health during that five months, from the cessation of nausea to the attack of flooding, that she had not enjoyed before for many years. She had borne two children, and had miscarried previously, but the uterine contents had then been expelled promptly.

To illustrate how much meddling the uterus may undergo, when no predisposition to miscarriage exists: In the winter of 1878–9, a physician called me to see his wife, about whom he was somewhat concerned. He told me she was pregnant and that she must be at about the seventh month. There was no motion. There was a constant discharge from the vagina, which had a peculiar appearance and smell.

He gave me this history of the case: They had two children, the youngest eight years of age, and his wife thought these enough, in which view I fancy he coincided. At any rate, when she had passed the second month without being able to disturb matters, he began passing the uterine sound, sweeping it around between the uterine wall and the fetal ball, as far as he found practicable without using a degree of force that might do mechanical injury. This had been kept up for a part of each month, once a day, and sometimes oftener. After a time a muco-purulent discharge had come on, and some days previous to the time I saw her the membranes had ruptured and the waters had come away; since which time a more profuse discharge had continued, which probably consisted of amniotic fluid and muco-pus. No motion had been felt for some time before the rupture of the sac, and no sign of uterine contraction had appeared. The woman was nervous and somewhat alarmed at the state in which she found herself, but presented no symptom of absorption. Sulphate of quinine, in 7½-grain doses four times a day, was followed in a couple of days by active contractions, which terminated the case promptly. The fetus was dead and, according to the husband's account, had been so for some time. A prompt recovery ensued.

The following case is an illustration of premature delivery following eclampsia: In January, 1876, I was sent for to see Mrs. E. R——. It was her fourth or fifth pregnancy. She had done well in all her previous pregnancies. This time she was much more fleshy than usual. At about the middle of the seventh month I was sent for, and on arriving found her in a convulsion. She had told her husband she could not see, when he sent for me immediately. The convulsion was severe, and she remained unconscious after it ceased. She was plethoric; the pulse was hard; the face and surface remained dark, and the breathing shallow and unsatisfactory. Abstraction of blood seemed the most urgent indication. I accordingly bled her 16 ounces from a large opening, with the result that consciousness returned, and no more convulsions followed. The next morning the urine containing albumin, and being scanty, she was put upon a milk diet with appropriate treatment. She did not appear to be weakened by the venesection, and complained no more for just two weeks, when I was again sent for. Labor was quickly terminated. The skin slipped from the fetus wherever touched, and the odor of all was offensive. No motion had been felt since the day previous to the convulsion. As soon as the placenta came I irrigated the uterus with a solution of carbolic acid, carrying the tube to the fundus.

I left my patient comfortable, and returned next evening to find her with a temperature of 105° F. Severe pain in the head, back, and limbs; abdomen sensitive, but not tympanitic; little lochial discharge; pulse bounding, hard, and full. My patient was very ill, and the outlook was anything but bright. I sent for a medical friend in consultation, but he was engaged elsewhere and could not come. As the bowels were confined, I gave 10 grains of calomel, applied hot poultices to the abdomen, and then taking my station at the bedside, I gave 1 drop of fluid extract of veratrum viride every half hour until the pulse was compressible and less frequent, the skin moist, and my patient sleeping quietly. At 2 o'clock I went home, returning at 10 A. M. to find her with a facial erysipelas; no abdominal tenderness; lochia returned, and no sign of pelvic disturbance.

She had had facial erysipelas on two previous occasions, and this progressed to recovery as the other attacks had done.

When I left my patient she had obtained relief from pain and was sleeping quietly. Although not feeling quite sure that we were out of the woods, I felt confident that the careful and judicious use of the veratrum had been an important factor in procuring that relief, and that I had been equal to the occasion, when the occasion was a serious one. When I saw that facial erysipelas the next morning I thought that luck would beat science every time. I still believe the veratrum conduced to the comfort of my patient, but must attribute the apparent metastasis to the *vis medicatrix naturæ.*

The treatment of abortion will depend upon the period of pregnancy, and for some reason it is often difficult to learn from the patient anything at all definite on this point. This is not so with all, and when a woman tells me without hesitation that pregnancy must date from about a certain period, I usually find her statement corroborated. But when I am told that my patient is very irregular, so much so that she did not dream of pregnancy when she had passed two months; that she was unwell a little the third month, but went out in the wet or cold, which put a stop to it; she did not think that strange, so irregular is she that menstruation is looked upon as a phenomenon, and when she was taken with flooding she did not know what to think, I expect to find that pregnancy is well advanced. Having attended to any urgent symptom that may present I try to get as detailed a menstrual history of the past five or six months as possible, and unless my patient is a really phenomenal liar it will lead to a pretty correct conclusion. Unfortunately they are sometimes phenomenal, of which the following is an illustration:

In June, 1887, a gentleman called me to see his wife. He told me he thought she was aborting, and feared she was flowing to excess. He thought she was over all trouble last night, but this morning she was feeling very weak, and had lost a good deal through the night. Vaginal examination revealed an os slightly dilated. The index finger failed to reach anything in the cervix, which was soft and dilatable.

This condition gave me the impression that either fetus or placenta had passed. Upon questioning my patient I was assured that nothing had passed but blood and blood clots, which had all been examined. It was evident the somewhat free loss of blood would exsanguinate my patient unless soon controlled, and I proposed to empty the uterus. A neighboring physician was called in who agreed with me that its contents should be immediately removed. The uterus did not seem very much enlarged, but our patient was one of those who could give no idea of the date that pregnancy occurred; in fact she had not thought she was pregnant.

Having douched the vagina with an antiseptic and prepared my hand, I very easily passed the index finger through the cervix and up to the fundus to find the uterus empty, except for a soft clot in the cervix and the uterine walls relaxed. She had objected to an anesthetic, and in my astonishment I said to her: "And you say that nothing could have passed from you?" She replied: "Impossible; nothing could have passed without my knowledge." The uterus soon contracted upon my finger, expelling it, and giving a hypodermic of ergot, and putting on a compress externally, hemorrhage was soon under complete control. I learned afterwards that she did not think either of the doctors knew what ailed her.

It may be better to make an examination of the case without a preconception of its nature. If we find the os and cervix dilated, or easily dilatable, and nothing presents, we may believe that something has passed away. If the patient has been pretty constantly on her feet, she may be unable to tell whether either fetus or placenta has come away. If hemorrhage continues we should ascertain the actual condition by examination. The rule that if the os is dilatable and the fetal ball within easy reach of the index finger, abortion should be looked upon as unavoidable, seems a satisfactory one.

If contraction is regular and sufficient we may wait for the expulsion of either fetus or placenta, or both. If the membranes rupture, the uterus usually takes a rest upon the delivery of either, frequently of several hours. It has been my practice under these circumstances to tampon the vagina and wait for the return of pain. The tampon should be renewed once in twenty-four hours and the vagina douched with an antiseptic before its renewal. The tampon may consist of a strip of gauze or a bit of canton flannel, wrapped around a rubber tampon, which is introduced and inflated with water or air. This tamponing has been my practice when my patient has been near me. Some morning I find that pain has been felt during the night and the placenta lies upon my tampon. It may be the first or second day, or it may be a week before this happens. I think it is hastened by giving regular doses of sulphate of quinine, 7 or 8 grains, at intervals of six hours.

At times my patient has lived at such a distance from my office that I could not visit her every day, and in many cases they could not afford to employ a physician to make such trips frequently. On all such occasions I have pursued a course that enabled me to leave my patient with safety. Observing the strictest rules of asepsis and antisepsis, I have proceeded to empty the uterus at once, usually with the index finger. If the patient objects to the use of an anesthetic, and if we find the os soft and dilatable, we may proceed without one and frequently with but little complaint. If it is hard and firm an anesthetic is almost essential. Having given the patient instruction to avert subinvolution, she may be left feeling that she is in safety. I have pursued this course in many cases and all have done well. Having given the matter a good deal of thought, I have on several occasions more recently proceeded immediately after the expulsion of the fetus and cessation of pains to empty the uterus, usually giving 7 or 8 grains of quinine beforehand.

I think that if one has thoroughly familiarized himself with the principles of asepsis and antisepsis, in practice as well as in theory, and keeps himself constantly prepared to operate in such a case, observing all necessary details, this is by all means the proper course to pursue. It should, however, be borne in mind that talking of microbes and carrying a vial of bichloride in the pocket, constitutes neither asepsis nor antisepsis, and perhaps the only danger in the universal adoption of the practice of emptying the uterus at once, when satisfied that abortion must occur, is that men will undertake it who have not conquered the necessary details, feeling safe because they feel the bottle of bichloride in their pockets.

Once the uterus is completely empty, it is very seldom that hemorrhage continues, or if it does continue, it yields at once to ergot. Cases do occur, however, that do not yield to drugs. As an instance of this kind: some years ago Dr. H—— called me to see a patient of his who had aborted two weeks previously. He controlled the hemorhage at the time, but it returned every day or every second day until she was quite anemic. He had employed all the usual remedies and without lasting effect. The husband told us this was the fifth abortion in three years. Taking a pocket faradic battery we wrapped one of the brass handled electrodes with iodoform gauze and introduced it into the vagina, well up to the os uteri, and applied a sponge electrode to the abdomen over the region of the uterus, turning on a current that could be felt but that was not painful, for 20 minutes. The hemorrhage ceased at once. We used the current for several successive days, although no hemorrhage appeared after the first application.

At the end of the third month there is very little placental tissue. Sometimes it is attached to the outside of the fetal ball, at others it adheres to its site on the internal surface of the uterus, perhaps so firmly as to require the use of the dull curette. Sometimes previous to the third month the fetal ball becomes ruptured and the very small fetus escapes, leaving its envelopes. In this case, to avoid putrid infection, they should be removed, and it may here be easier to use the small curette, as it requires little dilatation.

At the fifth month I would not think of risking tamponing after the delivery of the fetus, and waiting for the delivery of the placenta. Previous to the end of the fourth month, while it may not be unsafe when properly done, I think as much risk accompanies it as attends the immediate emptying of the uterus, and that the man who would do the one safely, would be quite as likely to do the other so.

To resume: Previous to the end of the third month, if the fetal ball becomes ruptured and the fetus escapes, leaving its envelopes, and they cannot be seized and removed by gentle traction, they may be removed by the curette, or by the index finger, as seems most convenient.

For the next month the tampon may be used while waiting for the expulsion of the placenta, but its prompt removal gives just as good results and saves time and expense.

This is the treatment of abortion as distinguished from miscarriage. In miscarriage, that is after the end of the fourth month, it is not safe to tampon and wait after the delivery of the fetus, as the uterus is distensible at this period, and hemorrhage may take place internally to such an extent as to seriously compromise the health or even the life of the patient. This is true in a greater degree in premature delivery. Whatever course is pursued, the details of asepsis and antisepsis should be strictly observed.

WILLIAM HARVEY.[1]

By Luke Robinson, M.D, San Francisco, Cal.

Read before the California Academy of Medicine.

In this Columbian year, amidst our costly and showy celebration of the birth and labors of the great discoverer, whose heroic achievements gave to humanity a new world with vast expanse of territory and endless resources of wealth, it is meet that we turn our attention to that other great discoverer in the realms of science, whose life work is the beginning of modern medicine. I refer to the illustrious Harvey, the discoverer of the circulation of the blood.

Harvey was born at Folkstone, England, on April 2, 1578. Our future physician was placed, when ten years of age, in a grammar school at Canterbury, and there imbibed his preliminary knowledge

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⁂[1] This address was delivered before the Academy of Medicine, by Dr. Robinson, on the occasion of the presentation by him of a handsome etching of Harvey to the Academy.

of Latin and Greek. In 1593, being then sixteen years of age, he was entered at Caius College, Cambridge, graduating in Arts in 1597.

Having selected medicine for his profession, he betook himself to Padua, then the most celebrated school in the world. Here he became the student and assistant of the great anatomist, Fabricius, and here also he listened to the lectures of the world-renowned surgeon, Julius Casserius.

He studied with the utmost diligence, and from the first attracted the marked attention of his teachers, who were surprised at the accuracy and extent of knowledge which he evinced in the examinations preparatory to his doctor's degree. This was conferred upon him April 25, 1602.

He then returned to London, where he settled in practice, and in 1604 married a daughter of Launcelot Browne, a Fellow of the Royal College of Physicians and physician to Queen Elizabeth. Harvey was admitted a member of the College October, 1604, and a Fellow June 5, 1607.

In 1608, having been strongly recommended by King James the First, he was elected physician to St. Bartholomew's Hospital, where he first expounded those original and complete views on the circulation of the blood which have since rendered his name immortal. It was not, however, until 1628 that he gave his opinions to the world at large, in his celebrated treatise, entitled "Exercitatio Anatomica de Motu Cordis et Sanguinis."

From the Christian era until the sixteenth century only two changes had been made in the theory of the circulation. Galen had discovered that the arteries contained blood as well as the so-called vital air or spirit. Linacre, early in 1500, knew that the blood was not stagnant, but had no conception of a continuous circulation, either in the lungs or system. The theory just prior to Harvey's discovery was that one kind of blood flowed from the liver to the right ventricle of the heart, thence to the lungs and general system by the veins, and that another kind flowed from the left ventricle and general system by the arteries. They also supposed that the septum of the heart was pervious and allowed blood to pass in some degree from the right to the left side. Neither at this time was the function of the heart as a motor power in the movement of the blood understood. Silvius had, it is true, discovered the valves of the veins, and Servetus, as well as Fabricius, had described in an indefinite way, the pulmonary or lesser circulation.

It was left to Harvey to enunciate the complete doctrine of the circulation of the blood, as well as to explain and give value to the discoveries of Fabricius and Servetus. He illustrated and proved, by numerous experiments, that the mechanism of the valves of the veins is not, as then taught by Fabricius, to control or check the flow of blood from the heart, but to favor its flow to the heart. Except the discovery of the capillary circulation, the work of Harvey was complete. This was described a few years after Harvey's death by Malpighi, but no one can read Harvey's work without believing that even the connection between the arterial and venous radicles was fully made out and understood.

Harvey was fortunate financially in his professional career. He was physician both to James the First and his ill-fated son, Charles the First. He was also lecturer and physician to St. Bartholomew's Hospital, where his best public work was done. His large fortune was left to the endowment of the Harverian Library of the Royal College of Physicians, which was unfortunately mostly lost in the great London fire of 1666. He retained the Lumlian lectureship, the duties of which he conscientiously discharged to the last. He had lived to see his grand discovery of the circulation of the blood universally accepted and inculcated as a canon in most of the medical schools of Europe, and he is said by Hobbes to be the only one who conquered envy in his lifetime and saw his new doctrines everywhere established. He died June 3, 1657, at the advanced age of 79 years.

The private character of this great man, says Aiken, appears to have been in every respect worthy of his public reputation. Cheerful, candid and upright, he was not the prey of any mean or ungentle passion. He was as little disposed by nature to detract from the merits of others as to make an ostentatious display of his own. He lived on terms of perfect harmony and friendship with his brethren of the College, and seems to have been very little ambitious of engrossing a disproportionate share of medical practice.

533 Sutter street.

MEMORANDA.

A Case of Spina-Bifida.

Very recently I was sent for to see an infant, then 32 hours old, which was said to have a "lump on its back out of which blood was coming." The baby—the third child—was full-term, undersized, but otherwise fully nourished. The labor had been precipitate—"three pains only;" family history good. A large tumor at the level of the dorso-lumbar region, about the size of an adult fist, reddish-purple and opaque, gave ample justification for the remark, "a lump on its back." A thin sanguinolent fluid was oozing from two valvular ruptures situated on the anterior and inferior surfaces of the tumor; this, the mother stated, had been coming away since the child was born. There was no tension in the sac, which was thick and doughy in consistency and its outer "cuticle" very much modified, being in a state of serous infiltration from constant contact with the fluid. Temperature normal; heart sounds rapid, but pure; pulse tension sub-normal. There had been no movement from the bowels since birth. The anal region was very much congested, but the canal was patent; urine scanty. Child crying constantly, but taking nourishment; anterior fontanelle depressed and toneless. Cephalic development normal, no spinal curvature, but talipes varus in right foot; birth had been head presentation. Prognosis given as fatal, as the cerebro-spinal fluid had freely drained off; sac collapsed; edges of rupture of a greyish gangroid appearance. Convulsions predicted, and six hours later, 48 after birth, the first spasm was noticed, preceded by distinct cyanosis; intensity and frequency of spasms increase. At first, during the intervals, the circulation became normal, the dusky hue passing away. Ultimately, however, the cyanosis became persistent, and death took place 72 hours after birth. A limited *post-mortem* examination was permitted. The sac wall was thick, just like wash leather. It contained about a drachm of dark fluid of fetid odor; lining of sac dusky red; unilocular and sessile. Posterior half of spinal canal of last dorsal and first lumbar vertebra entirely absent. The lining of the sac was apparently a reflection of the dura mater and arachnoid, the distension being in the sub-arachnoid space; as the cord was free and not distended (*i. e.*, normal central canal), lying on the floor of the sac. No doubt when fluid was present it would have floated the cord into the hernia and produced a meningo-myelocele. The clinical points of interest to note are the rapid labor, the early gangroid appearance of the ruptures, the slight functional disturbance at first, consequent upon the fluid drainage; the delay of convulsive seizures which, in the later attacks, demonstrated both tonic and clonic conditions; motion and sensation in lower half of body apparently normal. FRED. W. D'EVELYN, M. D.

San Francisco, Cal.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and

HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Results of Conservative Electrical Treatment in Gynecology.—Intrauterine electrotherapy (faradic-galvanic or sinusoidal), as it is advised by APOSTOLI, wisely, rationally, and patiently applied deserves to be placed at the head of gynecologic therapeutics: (1) Because it most often assures an amelioration of symptoms, which in many cases amount to a cure: (*a*) It is almost a specific in endometritis and the principal functional troubles (amenorrhea, dysmenorrhea, metrorrhagia). (*b*) It is very efficacious in even cystic fibroids. (*c*) Often, but not always, useful in peri-uterine, non-suppurative phlegmasia. (*d*) Useless in itself in cystic tumors of all kinds, and in suppurative lesions of the pelvis and annexes. (2) Because, in cases in which it is inefficacious, it aids, by its very impotence (through the attention and harmless study of its operative and post-operative reactions) in cleaning up or confirming a doubtful diagnosis, thus imposing or precipitating delayed or forbidden surgical intervention. (3)

Because, if the immediate symptomatic consequences of its application are generally favorable, the remote consequences are not less interesting on account of the ulterior pregnancies often observed.—*Actualité Médicale*, May 15, 1894.

Retention of the Placenta in Tubal Abortion.—The phenomena of tubal abortion may be explained by the anatomical fact that the placenta remains adherent to the tubal wall. When the tube continues swollen and painful after a hemorrhage resembling an abortion; when metrorrhagia again occurs without completely emptying the tube, we are authorized in acting upon a diagnosis of incomplete tubal abortion in order to avoid the grave complication of intraperitoneal rupture. The retention of the placenta in abortion may be explained by anatomical considerations. In normal evolution of the placenta the uterine sinuses progressively enlarge until the close of pregnancy, and, theoretically, these sinuses finally form a single liquid sheet between the maternal and the fetal tissues. Placental detachment is then the normal accompaniment of complete gestation. In abortion, on the contrary, many of these sinuses do not develop, and the placenta remains solidly attached to the uterine walls. Furthermore, after expulsion of the fetus the placenta ceases to grow, and consequently to favor its own expulsion, which depends upon this very growth. In the tube the situation is still more unfavorable, for the tubal mucosa is without the special vascularization of the uterus, and the sinuses develop with still less facility than within that organ. The placenta is thus expelled piece by piece, accompanied by hemorrhages following menstrual or accidental congestion of the genital organs.—*Progrès Médicale.*

Surgical Treatment of Uterine Prolapsus.—M. RICHELOT lays down the following general principles in the treatment of uterine prolapsus. Those cases in which fibroma, or lesions of the annexes indicate extirpation of the uterus, are not in question. Here, prolapsus only renders an operation less difficult. In simple prolapsus, if the uterus is small, and exuberance and flaccidity of the walls not extreme, colporraphy is the treatment *par excellence;* but if the uterus is large, and hypertrophy of the cervix indicates that the weight of the organ may prevent union or cause relapse, supra-vaginal amputation of the cervix—not as performed by Hugnier, but according to the modern method—should precede colporraphy. If excessive relaxation of the tissues renders the success of vaginal anaplasty doubtful, we may, anaplasty still remaining the basis of the treatment, have recourse to auxiliary methods, to Alexander's operation, or to hysteropexy. In spite of fixation of the uterus, prolapsus often remains unrelieved. Hysterectomy must be considered among auxiliary methods, but it is well to remember the mechanism of prolapsus; it is not the uterus that pushes down the vagina, but the vagina which falls and draws down the uterus. It is true that the extirpation of a large, painful and hemorrhagic body is desirable, and may be more benign and efficacious than supra-vaginal amputation with circular suture of the vaginal wound to the stump; but it is not radical treatment of prolapsus. Hysterectomy is accessory, and necessarily followed by a new operation, and we must assure hemostasis by ligatures to the exclusion of forceps, in order to leave the field free for immediate colporraphy. Thus, hysterectomy is inferior to a method that succeeds from the first, and, willingly or unwillingly, we must always return to colporraphy.—*Union Médicale.*

SURGERY.

By T. W. Huntington, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal., and

G. F. Shiels, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

Early Operation in Osteomyelitis.—At the recent German Surgical Congress (*Deut. med. Woch.*), Kuster spoke on this subject. He included in it all inflammation of bone caused by microörganisms, even when the disease does not begin in the medulla, but in the spongy or compact bone, or even in the periosteum. The direct cause of the disease can penetrate through the unwounded skin, but furuncles, etc., are stated to be apparently always intermediary. Scratching, etc., can give rise to the inoculation. The author would regard defective cleanliness of greater significance in the etiology than has previously been believed. Scraping away the disease is recommended as early as the diagnosis is made (the marrow only being scraped away in the severest cases). He refers to 24 cases. Of 14 operated on in the first and second weeks all recovered, 5 after a sinus; of 3 in the third week 2 died and 1 recovered after a sinus; of 3 in the fourth week all recovered, 1 after a sinus; of 4 in the fifth to seventh weeks 2 died, the others recovering, 1 after a sinus and the other with ankylosis of the joint. After a very severe onset the author repeatedly saw, when the focus of the disease was laid bare, a small hemorrhagic infiltration, or a small center of pus, and when this was scraped away the wound healed rapidly. The more extensive the purulent infiltration the more uncertain the result. With an extensive lesion the author carries out the osteoplastic operation after Lücke. In the discussion Nolden did not believe in any relation between defective cleanliness and the disease. Körte referred to 22 cases, 6 of which were fatal. Schede distinguished between the general infection and the more strictly local disease; in the former the surgeon is almost powerless. Linder drew attention to the variability of the disease in frequency and virulence. Sonnenburg thought that the nature of the case must determine the procedure to be adopted. Gussenbauer referred to some 400 to 500 cases. Necrosis occurred in the second stage, and only exceptionally in the first three days. He had no experience of operation in the first stage. Necrosis had not been prevented in his cases.—*British Medical Journal*, June 9, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

Systematic Procedure in Operations for the Relief of Intercranial Disease Secondary to Ear Suppuration.—Urban Pritchard has formulated the following rules as a guide in operating for intercranial disease secondary to ear suppuration: (1) First thoroughly open the antrum and explore the mastoid cells. (2) Failing to find sufficient evidence to account for the whole of the symptoms, the wound in the skull should be enlarged backward so as to expose the lateral sinus, which should be explored by the hypodermic syringe. At the same time subdural abscesses may be carefully looked for. (3) If a clot be found in the sinus, the internal jugular vein should be tied and the sinus opened and entirely cleared of its contents. (4) If there is any suspicion of of cerebral or cerebellar abscess, exploratory punctures may me made above and below the sinus, and pus, if found, evacuated. The author thinks the opening of the mastoid cells of great importance, especially to prevent recurrence of an intercranial affection. In enlarging the skull wound he prefers the chisel and mallet. Hoffman's gouge forceps are also of great assistance. The important point is to expose the lateral sinus and the dura-matter immediately above and below it, as by this means we obtain access to both the middle and posterior fossæ of the skull, and can explore both the cerebrum and cerebellum if necessary. If thrombus of the sinus is found, the internal jugular vein should be tied below any clot that may be felt in the vein itself. The sinus should be freely opened and the contents thoroughly removed by means of syringe, sharp spoon, etc., free bleeding from the upper end being encouraged; this bleeding can readily be checked by plugging, when we are assured that the contents of the sinus have been evacuated.—*Archives of Otology.*

Syphilitic Inflammations of the Ear.—JONATHAN HUTCHINSON says: "Deafness and facial paralysis, in connection with acquired syphilis, are both extremely rare; the former is rather the more frequent of the two. I have seen several cases of symmetrical, absolute and permanent, deafness in the secondary stage of syphilis. The complication of facial paralysis, although it occurs in exactly the same class of cases and is due to the same character of lesion, is less frequent, usually less complete and more easily recovered from, and I have never seen it on the two sides at once. It is generally curable by treatment. The use of specific measures should be prompt and vigorous in any case of acquired syphilis in which the patient is threatened with deafness. More especially is this true if the deafness comes on in the secondary stage; for it then often runs a rapid course, and if it once has become complete recovery is very rare. It is well to require a patient suffering from secondary syphilis to remain in his bed or room, and use mercury in the manner to get the most rapid effect, when he is suffering with an affection of the organ of hearing. In the tertiary stage of syphilis, when deafness occurs it is of far less importance. It rarely proceeds to extinction of the function and is seldom permanent. One should guard to distinguish cases of deafness due to the condition of the throat during secondary syphilis.—*Archives of Surgery*, April, 1894.

Removal of the Ossicles.—DR. SHEPPARD formulates the following conclusions in regard to this procedure: (1) Cocain can be used with advantage as the anesthetic in a considerable proportion of suppurative and catarrhal cases. (2) Removal of the malleus alone is not, as a rule, sufficient in either class of cases. (3) Removal of the malleus and incus will cure a large majority of the suppurative cases and improve hearing in about half of them. (4) Removal of all three ossicles will sometimes fail to cure middle-ear suppuration. (5) Removal of the stapes entire gives better results than when the foot-plate is left in place, although a moderate proportion of the latter class show very good results. (6) Reactive inflammation seems as likely to occur in cases of partial excision of the membrana tympani as in total excision, with removal of the ossicles. (7) Unpleasant symptoms, such as severe and prolonged dizziness, vomiting, facial paralysis, and meningeal irritation, occur in about a fourth of the cases. (8) In a majority of cases the tinnitus has remained unchanged.—*Annals of Ophthalmology and Otology.*

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M.D., Sacramento, Cal.

Treatment of Venereal Lymphadenitis.—NOBLE (*Archiv. f. Dermatologie u. Syphilis*) reported to the Vienna Dermatological Society the results of his investigations into the method of treating venereal lymphadenitis proposed by

Lang. The treatment pursued is as follows: When a case was presented in which abscess-formation had taken place, this was punctured with the point of a bistoury and the contents evacuated by moderate pressure. The remaining cavity was washed out with a 1-per-cent. solution of nitrate of silver driven in with some pressure. This solution was evacuated through the puncture and pressure bandages applied. In very large abscesses two puncture points were made, more efficient drainage being thus secured. This treatment of puncture, evacuation and injection was continued two or three days, until there was no further secretion. This usually required but two injections. At first, after treatment there is a thick, chocolate-colored exudate; finally only blood-stained serum escapes on puncture, and this, if it persistently accumulates, may often be left to absorption. When a case was presented in which abscess-formation was not complete, showing uncertain fluctuation, the injections of nitrate of silver were forced not only into the cavity left by partial evacuation of the pus, but also into the surrounding infiltrated tissue. This causes, in two or three days, a painless softening of the diseased glands, or even brings about a more favorable result—*i. e.*, prompt resolution of the inflammation. The treatment is contraindicated in the strumous form of buboes. These cases require radical operation. In 70 cases treated according to the method just detailed, the average period of healing was 10 days. In 8 cases healing occurred in from 3 to 5 days. In 8 cases cure was not accomplished for 25 to 30 days. In the great majority convalescence was complete in from 5 to 10 days.—*Therapeutic Gazette*, June, 1894.

Recurrence of Hard Chancre.—PROF. NEUMANN presented, at a recent meeting of the Vienna Medical Society, a patient suffering from recurrence of hard chancre at the point of the initial lesion, on the upper lip. The chancre, which occurred after an interval of 4 years, presented exactly the same appearances as the first, and on examination was found to be sclerosed, and not gummous. Prof. Neumann believed it wrong to regard the lesions of syphilis as transitory and ephemeral in character. He had become convinced by microscopic examination that, even when all the clinical signs had disappeared, there remained proliferating cells in the tissues, especially along the vessels, and that under certain favorable circumstances these cells might again become active and give rise to a recurrence.—*Universal Medical Journal*, June, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Chloroform in the Treatment of Seasickness.—Some months ago we published an abstract of an article upon this subject, and since that time PROF. CHARTIERS, Glasgow, has collected three hundred cases reported by ninety ship-surgeons sailing on various Atlantic lines, from which he is able to formulate comparatively definite conclusions as to the value of the drug. (1) In long sea voyages no prophylactic benefit can be secured by the use of chloroform, unless for two nights before embarkation the passenger pays due attention to the stomach and bowels by taking a cholagogue pill. Further, in the case of a person who dreads a voyage, a dose of the medicine should be taken for one or two nights before starting. (2) The diet on board ship should be "pure and dry." Soup, pastry and sweets should be especially avoided, and no full meal should be indulged in. A hypnotic dose (one tablespoonful and a half for a male, and one tablespoonful for a female) should be taken for three nights. (3) In short voyages, when the steamer leaves, perhaps, at 10 P. M., the passenger should immediately retire to rest and take one of the doses mentioned. (4) In a shorter passage across the channel a teaspoonful should be taken before going on board. (5) By following these directions immunity from seasickness is obtained in the great majority of cases: but if they be not followed, it is to be remembered that chloroform has not any effect in arresting an outburst of vomiting. If it is given in a teaspoonful dose every ten minutes until a tablespoonful and a half, or a tablespoonful, has been taken, it will invariable check retching and depression.—*Lancet*, April 21, 1894.

Peroxide of Hydrogen in Stomatitis.—BOENNECKEN, in a paper on stomatitis, insists upon the importance of paying attention to the mouth during acute febrile or wasting disease; stomatitis originating in the neglect of attention to the teeth or gums, may have a serious influence in retarding convalescence. The solutions of chlorate or permanganate of potash, generally used for cleaning the mouth, are not sufficiently concentrated to have an antiseptic action, and at the same time are apt to be painful. Peroxide of hydrogen is not poisonous; does not cause pain, and has an effective antiseptic action even in solutions so weak as two per cent., or even less. He states that by its use fetor is corrected in a few minutes, and that its continued use was followed by a marked improvement in the condition of the epithelium in twenty-four hours, and complete cure of even severe cases in five or six days. LEO, in the subsequent discussion, stated that a stronger solution was needed in chronic stomatitis.—*British Medical Journal.*

Electricity in Chronic Rheumatism.—MUSSY speaks very favorably of this mode of treatment if carried out patiently and systematically. Treatment must be both general and local—the former by means of the alternating dynamo current in the electric bath, or else by means of statical machines, the latter by the continuous current applied to the joints. The mode of procedure is as follows: When the joints are tender and painful a current of ten to thirty milliamperes is made to transverse them in various directions for a period of from ten to twenty minutes at a time. If movements of the joint are difficult, or if muscular wasting be present, the treatment is to be further extended to the surrounding nerves and muscles, using the negative pole chiefly for them, and interrupting the current frequently to throw the muscles into contraction. Any tender points may be touched with the faradic brush for two or three minutes, or with the positive pole and constant current. The progress is slow but effectual.—*British Medical Journal.*

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Naupathia or Sea Sickness.—SKINNER formulates the following conclusions: (1) The principal symptoms of naupathia result from the lowering of the patient's arterial blood pressure. This is a condition *sine qua non* of their development. (2) Sea sickness in a person otherwise healthy and not too aged is *promptly curable* in a vast majority of cases. (3) Even an aged person, or in persons having certain affections of the circulatory apparatus, there is often amelioration of the general condition by the employment of the new method of treatment. (4) The treatment consists in the hypodermic injection of from half a milligramme to a milligramme of atropine sulphate, associated with a milligramme of strychnine sulphate (or nitrate), dissolved in a cubic centimeter of distilled mint water. (5) The administration of these eminently toxic substances demands a great degree of attention, prudence, and supervision on the part of the physician, who alone should be the judge of the opportunity of their administration and of their dose in each individual case. Given at proper times and in suitable doses, however, no harm whatever will follow their administration. (6) The sympathetic nervous system plays a preponderating role in the causation of naupathia. (7) Naupathia, or sea sickness—an affection without known anatomical lesions, and of which the predominant symptoms have their origin in the nervous system, and especially in the sympathetic or ganglionic nervous system—ought to be regarded as a neurosis of the sympathetic. (8) The neurosis may recur during the course of a long voyage, but each attack is almost always amenable to the same treatment.—*New York Medical Journal*, December 30, 1893.

The Kidneys in Pneumonia.—In 180 cases of pneumonia, with 45 deaths, REICHE examined the kidneys in 40 cases, 34 men and 6 women. In these cases no macroscopical changes were evident. Microscopically, however, typical changes could be demonstrated. The changes were embraced under the following heads: (1) The changes involved only the cortex. (2) The changes implicated the secretory parenchyma, leaving the interstitial tissue intact. (3) Exudates were found in the capsules of the glomeruli. In 5 cases, the changes were caryolitic and necrobiotic, whereas, in the remaining cases, the changes implicated the protoplasm of the cells, which were swollen and broken down. These changes were not of an inflammatory but of a degenerative nature. They can be referred, as in cholera, typhoid fever, etc., to toxic, *i. e.*, bacteritic products. The so-called febrile albuminuria in pneumonia is the clinical symptom of these degenerative renal changes, although this symptom may be absent notwithstanding the changes. In the renal parenchyma, pneumococci were demonstrable and accepted as the inciters of the degeneration. The pneumococci could be cultivated on agar, and the cultures infected animals. The writer concludes that the presence of albumin, and even casts in the urine of pneumonic patients is not a *signum mali ominis*, inasmuch as it is dependent on a degenerative process capable of reparation.—*Münchener med. Wochenschrift.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Psychical Disturbances in Diabetes.—DR. JERZYKOWSKI has published an article on psychical disturbances occurring in patients suffering from diabetes, of which he has observed several cases. In one patient, a man aged 50, there was profound melancholia, with attempts to commit suicide, and in another, an old woman, there was also melancholia. In a third case, that of a widow aged 61, there was also considerable mental disturbance. In none of these cases was there any hereditary tendency to insanity. The author also mentions the glycosuria, sometimes occurring after sudden mental shock, as an example of the relationship between diabetes and mental affections. He maintains that in a large majority of cases the mental symptoms are actual complications of diabetes, and not secondary. He states that the most common of these phenomena are alterations in the intellectual powers of the special senses and of memory. The cases of melancholia above noted are less frequently met with.—*Lancet.*—*American Journal of Insanity*, January, 1894.

Diagnosis of Epilepsy by the Urine.—DR. GILLES DE LA TOURETTE claims that a diagnosis between hysterical epilepsy and that due to neoplasm can be made by examination of the urine. He has found that there is an increase in the elimination of urea and phosphates during a convulsion due to a tumor, while the amount execreted during an attack of hysterical epilepsy is diminished.—*Boston Medical and Surgical Journal.*

Antipyrinomania.—CAPPELLETTI reports a case in which the taking of antipyrin had developed an antipyrin-habit. A hysterical woman, 25 years of age, had increased the dose of the drug, taken at first under medical direction for the relief of headache, until she was taking eight grammes *per diem*. Her headache did not improve, but whenever an attempt was made to diminish the dose of antipyrin, an attack of nervous excitement would set in. The physician first tried to reduce the dose suddenly, but nausea and vomiting followed, accompanied by complete anorexia, palor, extreme feebleness of the pulse, general depression, and subsequently convulsions, loquacity, and hallucinations, and he was obliged to resort to slow and gradual diminution of the dose, with administration of chloral, bromide, sulfonal, and prolonged tepid baths. Recovery finally resulted, but was slow and painful.—*Révue Neurologique.*—*American Journal of Insanity,* January, 1894.

When a Physician may Testify Concerning a Deceased Patient.—Chapter 295, Sec. 836, of the New York Code, as amended in 1893, reads as follows: "A physician or surgeon may, upon trial or examination, disclose any information as to the mental or physical condition of a patient who is deceased, which he acquired in attending such patient professionally, except confidential communications and such facts as would tend to disgrace the memory of the patient, when the provisions of section 834 have been expressly waived on such trial or examination by the personal representatives of the deceased patient, or if the validity of the last will and testament of such deceased patient is in question, by the executor or executors named in said will, or the surviving husband, widow, or any heir-at-law, or any of the next of kin, of such deceased, or any other party in interest.—*Journal Nervous and Mental Diseases.*

FORMULÆ.

By GEO. B. SOMERS, M. D., San Francisco, Cal.

Alopecia and Tricophytosis:

Carbolic acid
Chloral
Tincture of iodine....āā ʒiii

S.—Paint the affected parts once a week in alopecia and three or four times in tricophytosis until a strong irritation of the skin is produced.—*Nouveaux Remèdes.*

Furunculosis.—SHOEMAKER uses:

Potassium chlorate
Lactate of iron.....āā gr. xviii
Tincture of columbo...℥iss
Simple syrup..........℥iii

S.—Dessertspoonful three times a day.

Muller's Fluid.—This fluid, which is perhaps the most commonly employed liquid for hardening pathological specimens, is made as follows:

Potassium bichromate	2 parts.
Potassium sulphate	1 part.
Water	100 parts.

—*Medical Record.*

Gonorrhea.—Ichthyol is much used for this affection in Paris. The formula is—

Ichthyol	ʒi
Water	℥viii

Three injections daily.—*Medical Press and Circular.*

Diphtheria.—PIÉDALLU claims extraordinary success in treating diphtheria by small doses of biniodide of mercury. His formula is as follows:

Syrup	1000.00
Iodide of potassium	50.00
Biniodide of mercury	0.50

S.—Teaspoonful every two hours for a young child. Dose is equal to about one-thirtieth of a grain of biniodide and about three grains of iodide of potassium.—*Boston Medical and Surgical Journal.*

Chronic Rheumatism:

Sodium salicylate	
Potassium iodide	āā ʒ ii
Syrup of orange	℥ ii
Water	℥ iv

S.—Four teaspoonfuls daily in water. —*Medical Press and Circular.*

Cardiac Stimulant:

Tinct. strophanthi	m xl
Tinct. zingiberis	ʒ i
Syr. simpl.	ʒ iss
Aq. chloroformi	*ad* ℥ viii

S.—Two tablespoonfuls three times a day—*Medical Press and Circular.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for May, 1894.—The deaths registered in 77 town districts of the State, during the month of May, in a population of 772,073, correspond to an annual rate of 15 a thousand, the total mortality having been 972. 73 deaths were due to zymotic diseases, giving an annual rate of 1.12 a thousand. Of these, 13 were due to diphtheria, 13 to cholera infantum, 15 to typhoid fever, 6 to diarrhea and dysentery, 5 to cerebro-spinal fever, 7 to whooping cough, 6 to croup, 2 to intermittent and remittent fevers, 3 to scarlet fever, 1 to measles, and 2 to small-pox. 283 deaths resulted from diseases of the respiratory organs, giving an annual rate of 4.32 a thousand. Of these, 168 were due to consumption, 76 to pneumonia, 31 to bronchitis, and 8 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.52 and .48, respectively. 77 deaths resulted from diseases of the heart, 9 from alcoholism, 5 from erysipelas, 35 from cancer, and 424 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 579,000, was 16.08. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Berkeley.

METEOROLOGY.

Summary for May.—*Temperature.*—The normal temperature of the State for May is 64°, the average for May, 1894, was 63°; a departure from the normal of —1.0°. The highest monthly mean was 88°, at the Agricultural experiment station near Tulare City; lowest, 43°, at the Summit, in the high mountain regions; the maximum, 111°, at Salton, on the 6th, in the desert regions of Riverside county; the minimum was 18°, at the Summit, on the 16th. The greatest monthly range was 68°, at Tulare; the least, 26°, at Point Reyes and Point Lobos. The absolute range in the State was 93°.

Rainfall.—The normal precipitation of the State for May is 0.89 inches; the average for May, 1894, was 1.21 inches; a departure from the normal of +0.32 inches. The greatest monthly precipitation was 5.64 inches at the Kennedy Gold Mine, near Jackson; the least, nothing, at a number of stations.

Wind.—The prevailing direction of wind was westerly.

Unusual Features.—The unusual meteorological feature of the month was the continued abnormally low average temperatures over the entire State, making the weather appear more like early fall than spring.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for May, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No. of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn ....Cal.	64.3	90.0	43.0	----	----	----	----	2.77	----	----	----	----	S.W.	Southern Pacific Company.
Berkeley......... "	55.0	75.0	42.0	65.0	49.0	16.0	7	2.01	83.0	13	9	9	S.	Obs. University of California.
Colfax........... "	60.4	86.0	32.0	----	----	----	----	3.45	----	----	----	----	S.	Southern Pacific Company.
Eureka........... "	51.0	63.0	36.0	56.0	46.0	11.0	8	1.31	94.0	10	14	7	N.W.	Weather Bureau Dept. Agr.
Fresno........... "	68.0	95.0	40.0	82.0	54.0	28.0	4	1.16	51.0	15	13	2	N.W.	" " "
Indio............ "	79.0	100	58.0	92.0	66.0	26.0	1	T.	18.0	27	4	0	W.N.W.	" " "
Los Angeles.... "	60.0	80.0	46.0	70.0	50.0	20.0	3	0.20	80.0	5	20	6	W.	" " "
Monterey .... "	58.6	74.0	42.0	----	----	----	----	1.86	----	----	----	----	S.W.	Southern Pacific Company.
Napa........... .. "	63.0	83.0	40.0	74.0	52.0	52.0	5	1.49	56.0	12	12	7	S.W.	Station Napa Insane Asylum.
Oakland......... "	57.0	79.0	40.0	68.0	50.0	18.0	9	1.89	76.0	17	3	11	W.	Chabot Observatory.
Paso Robles.... "	67.7	95.0	45.0	----	----	----	----	1.15	----	----	----	----	W.	Southern Pacific Company.
Red Bluff....... "	67.0	95.0	43.0	78.0	55.0	23.0	9	1.46	56.0	18	7	6	N.W.	Weather Bureau Dept. Agr.
Sacramento. ... "	64.0	88.0	40.0	74.0	53.0	21.0	7	1.70	64.0	15	8	8	S.W.	" " "
San Bernardino "	63.0	87.0	38.0	78.0	48.0	30.0	4	0.56	70.0	20	6	5	W.	A. K. Johnson, M. D
San Diego....... "	59.0	70.0	45.0	62.0	55.0	7.0	2	0.09	80.0	14	10	7	W.	Weather Bureau Dept. Agr.
San Francisco.. "	55.0	72.0	44.0	61.0	50.0	11.0	6	1.31	87.0	11	8	12	S.W.	" " "
Santa Barbara.. "	58.0	74.0	46.0	64.0	52.0	12.0	4	0.91	76.0	11	11	9	W.S.E.	Hugh D. Vail.
Santa Cruz...... "	59.0	85.0	37.0	70.0	48.0	22.0	8	2.36	----	13	2	16	S.W.	W. R. Springer.
Yuma...........A. T.	77.0	102	50.0	93.0	61.0	32.0	1	T.	36.0	23	8	0	W.	Weather Bureau Dept. Agr.

T. means a trace of rain. Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: JULY, 1894.

THE MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

The forty-fifth annual meeting of the American Medical Association is conceded to have been in every way a success. Scientifically the sections were, as a whole, well attended, the papers numerous and of fair average character. Sections that were poorly attended, or that failed to organize, are usually in much the same position. The attendance at the meeting was larger than at several that have been held in eastern states. Including visitors and the ladies who accompanied the Association, there were about 1,200 persons in attendance. The total number who registered was 571, of whom 492 paid dues and 79 produced certificates of membership. The actual gain in membership has, therefore, been considerable, and, as we have ventured to predict, a large proportion of this will be permanent. At another time we shall give more precisely the gain to the Association from the Pacific coast states and territories.

The meeting of the Association on the Pacific coast after an absence of twenty-three years, was an event of widespread interest. The Association came to find a small guard of occupation that had held its ground for many years, some having joined on the occasion of the last visit. It has left us with renewed vigor, strengthened in its membership by the infusion of the healthiest professional blood to be found in this country, and with a tacit understanding that its coming will not again be so long postponed. That the profession on this coast, the cause of professional organization, and the progress of medicine, has been greatly benefitted, is apparent. Medical societies received a marked stimulus during the past year; new societies were organized; older ones, that had died from lack of interest, were revived, whilst those in more active existence gave signs of unwonted vigor. To many of the profession the Association was only a name or a memory, to these it is now a living reality whose influence cannot but be helpful in future years. The

American Medical Association to-day fully and amply represents all that is best in the profession of this country, and for general practitioner or specialist there can be no better organization for mutual help or for scientific or professional advancement.

This meeting of the Association derived a large share of importance from the fact that at it was to be considered the proposed amendments of Constitution and of Code. It is said that many eastern members remained at home, realizing that abrogation of the basic principles, of the Code at least, were impossible in the clearer ethical atmosphere of California. It is true that on either of these questions the profession here are not well informed, but it needed but little explanation to perceive that the abolition of the delegate system in general sessions and the destruction of the nominating committee would work an irreparable injury to the whole profession of the western states, amongst whom the Association had for so many years shown a selfish disinclination to meet. A later proposition to amend this plan by providing for mixed representation on the nominating committee left things precisely where they stood as far as voting power is concerned, the delegates who could be counted on as being present making a minority in the face of a, presumably, solid majority. A further proposition to permit delegates, after two successive years, to vote at all future meetings, only postpones the evil while rolling up an ever-increasing majority of those seeking control. The inevitable consequences of these measures would be to place the business control of the Association in the hands of the specialists, and to permanently exclude the majority of the membership from representation. The changes proposed in the Code were, as we have already pointed out, of a very radical character. In their very nature they are destructive of the principles upon which the Code is founded and which have, more than anything else, served as a rallying point, for all the years of its existence.

The arguments advanced by the supporters of revision of Constitution and Code were identical. Present conditions were urged as the cause of the Association's slow growth and its numerical insufficiency in relation to the whole profession. One eloquent speaker presented the picture of the British Medical Association with a membership of "20,000" and a flourishing and influential Journal, and urged the possibility of uniting the "100,000" practitioners in the United States in one grand association. This sounds very well from the platform, but the premises are false and the practical accomplishment of such an aggregation is utter nonsense. In the first place, the total membership of the British Medical Association, covering the entire British possessions, is considerably short of 20,000. The exact figures are not at hand, but the Association *Journal* only claims a circulation of 18,000, and we are unaware of any publication that would misrepresent itself in such a manner. The contention that there are 100,000 physicians in the United States that are eligible for membership, will be seen, on a little reflection, to be equally misleading. The third edition of the Medical and Surgical Register of the United States gives the membership of physicians as 105,000. From these must be deducted the unqualified, the poorly qualified, the 'pathists, and those debarred for various reasons. Admitting, for argument, that there are 50,000 physicians to-day that are eligible, it is as fallacious to assume that even that number can be brought into the Association by changes in Constitution or in Code as it is to assert that a fairly efficient Constitution and an exceedingly liberal Code holds them aloof. Those who adopt such arguments fail to read the history of the profession and of its organizations. The largest figure that can be counted upon is that, the units of which, alone, are eligible, viz: the combined membership of the State and local Societies. Here, again, history shows that the membership cannot be at once extended to embrace even this constituency. The history of every State Society and of most local Societies shows a comparatively small proportionate representation when compared with the constituency from which it could draw. From time to time spasmodic efforts are made to remedy this, and with only a partial measure of success. Many sincerely believe that they have discovered a cause in various conditions, but the great truth remains that in every community there are only a few who actively and earnestly seek and support scientific advancement and professional organization. These men now comprise the membership of the local and State Societies. If, as has been proposed, the Association at once include this number in its ranks, the element of expense may be considered by some, and, aided by indifference or lukewarmness. the aggregate continuing in the Association year after year would fall far short of the anticipation.

The social features of the meeting were certainly not neglected. In the face of an extensive commercial depression a large sum of money was raised, exclusively amongst the profession. Most of the leading medical societies contributed liberally, and individual donations were also generous. It seemed at first as if there might be some friction on the question of entertainment, but differences that had arisen through misconception were soon smoothed out and everything was harmonious at the time of meeting. Entertainments were provided for all the visitors, and in these the local profession participated most heartily. The ladies were not forgotten; special entertainments being provided for their benefit, and in fact a special organization had been effected to render their stay amongst us as enjoyable as possible. Had not the time been so fully apportioned there would, no doubt, have been several additional private entertainments, but in the short space of four evenings it was impossible to find room for all. It is, perhaps, invidious to mention any one entertainment as excelling another; yet it will be conceded that the reception by the Medical Department of the University of California was an occasion that will long be remembered by the profession at home as well as by their visitors from abroad. The excursion tendered to the Association by the profession of California was a most enjoyable one, in which every detail seemed to have been carefully supervised, and during which nothing occurred to mar the pleasure of the occasion. In fact, the meeting as a whole, whether viewed from its scientific or from its social aspect, leaves only pleasant memories, and all concerned in the entertainment of the guests must feel repaid by the universal satisfaction expressed on all sides.

It would be unfitting that we should close without some reference to the one man who did most and worked hardest to make the meeting of 1894 an assured success. DR. R. H. PLUMMER, the Chairman of the Committee of Arrangements, as an officer combines a large measure of executive ability, with an apparently unlimited capacity for hard work. To fill his position in a satisfactory manner is at any time an unenviable task, but to undertake this work in a locality where the Association had not met for almost a quarter of a century, and where all were ignorant of the necessary machinery, as well as the ways and means for conducting a meeting, was certainly a task of no small proportions. That the chairman acquitted himself well and successfully has been conceded on all sides. Throughout the meeting there was never a break down in programme or arrangements. Things at times moved slowly in the Registration Bureau, but this was due to an attendance much larger than any had anticipated, and the machinery was simply inadequate to the demands upon it. Even here there was no mishap, and no committee worked harder and more faithfully than that on Registration. We have not inferred that any one failed in his special duty, or that any officer was lacking in devotion to his task, but it is idle to deny that the unmixed pleasure of a grand success was mainly due to the unceasing and untiring efforts of DR. PLUMMER, whose only reward has been the emphatic thanks of all concerned.

NOTES.

Dr. G. L. Simmons.

Dr. G. L. Simmons, of Sacramento, the President of the State Medical Society, left for a prolonged vacation on June 17. The doctor, who had delayed his departure until after the meeting of the American Medical Association, will first visit his old home in Massachusetts, and, having spent some time in eastern cities, will then probably extend his trip to Europe, returning some time before the meeting of the State Medical Society, in 1895.

The Strange Tale of the Inverurie.

On June 19 the British barque Inverurie reached San Francisco, after a sixty-four days voyage from Sidney, and with the body of the Captain's wife on board, she having died two days before reaching port. The story, as published in the papers and authenticated by inquiry, is a strange and melancholy recital of human suffering. When the ship was about to leave Australia, Captain Willox states that he urged his wife, then about seven months pregnant, to precede him by steamer, so that she could obtain proper medical attention. Mrs. Willox, however, preferred to accompany him and shortly before starting a man named Armitage, accompanied by a woman who passed as his wife, applied for passage. Armitage stated that while not qualified he had had extensive experience in midwifery, whilst his "wife" had served as a trained nurse in the hospitals at Sidney. Their services were accepted and they took passage on board. All was not harmonious on the ship; charges and countercharges were made by officers and crew. In the unpleasant feeling that prevailed, it appears that the captain and second officer were on one side, with the mate and ship's company against them. Mrs. Willox' health appears to have been good while on the voyage, and in due course labor set in. According to one side of the controversy the captain had been drinking, and under the excitement he became more violent and demonstrative. Delivery was delayed and it appears that instruments were used. During the progress of the case the supply of chloroform gave out and the sufferings of the woman almost determined the captain to shoot her so as to put her out of her misery. He, however, did not carry out his expressed intention, but, apparently in a condition of frenzy, attacked the second officer, with whom alone he seemed to be on friendly terms. The mate then took the responsibility of ordering him into confinement and under restraint, where he was kept, while the man Armitage, assisted by his "wife" and the mate, effected the delivery of a living child. The captain was kept in confinement for some days, but his wife's condition becoming serious, he was released, as he states, too late for her to recognize him before she died. The stories as to the cause of the captain's condition are conflicting. Armitage and the mate stating that it was from drinking, the captain alleges that it was due to drugs with which he had been plied. The only person supporting the captain in his assertion is the second officer, who says that in eight months he never saw the captain take a drink. Upon the arrival of the ship the body of the unfortunate woman was taken ashore, and subsequently an autopsy was made by Dr. R. J. G. O'Connell, of the Coroner's staff. He reports that death was due to puerperal peritonitis and that nearly one-third of the placenta had been retained *in utero*. The whole affair is a most melancholy and unfortunate one, and it is impossible to regard the captain as innocent in the matter. The mate obtained his discharge from the ship, his character being given as "first class," whereas, under the circumstances, a most searching investigation should have been called for. In addition to this, a number of the crew have stated most positively that they will not go to sea with Captain Willox in command.

The Seligman Case.

Our readers will remember that some weeks ago Mr. Jesse Seligman, a New York banker, died rather suddenly at the Hotel del Coronado, San Diego. Mr. Seligman was prominent in the financial world, and his sudden demise excited a good deal of press comment. Following this, there appeared a number of statements ascribed to Dr. H. R. Heydecker, the resident physician who had attended Mr. Seligman during his last illness. The general purport of these statements was that the patient was suffering from extensive cardiac and renal trouble, and that he had been sent to San Diego by Dr. Alfred L. Loomis, of New York, who had stated that Mr. Seligman was not the subject of any organic disease, but was simply suffering from overwork and general prostration, and needed rest. An interview with Dr. Heydecker, that appeared in the San Francisco *Examiner*, was particularly strong, the doctor being quoted as expressing his surprise at the ignorance or carelessness displayed by the author of "Lessons on Physical Diagnosis." Dr. Heydecker's side of the case having been confirmed by an autopsy, the status of the case, as well as its clinical aspect, excited a great deal of comment in the profession. The following statement, kindly furnished by Dr. Heydecker, fully explains his position, and at the same time illustrates in a remarkable manner the trend of modern "journalistic enterprise." The doctor states that, owing to the strongly-expressed wishes of the Seligman family, he is prevented from giving more than a statement of his conduct in the case, as well as the report of the pathologist who examined the body. Dr. Heydecker says: "The articles which appeared about ten days apart in the San Diego *Union* and the San Francisco *Examiner*, respectively, and which purported to have been the result of interviews with me by reporters of said papers, were neither uttered by me, nor was even their existence known until I saw them in print. The first-mentioned article I have traced to a fellow physician who was called in during the last few hours of my patient's life to assist me. The second and most obnoxious newpaper report was manufactured by a reporter, to whom I had absolutely refused an interview, and who had given me his word, on hearing my reasons for this refusal, that he would publish nothing. The above statements I have been able to prove to the entire satisfaction of the family and of the physician, whom the paper tried to represent me as accusing of an error in diagnosis. As both these parties have been satisfied with the proof which I was enabled to bring, I shall not occupy your valuable space with the production of details. I always have had, and still have, the greatest respect and most friendly feeling for the physician I am represented as assailing. Regarding the case, I have only to say that a most careful pathological examination, made at the request and with the sanction of the family, has corroborated, in every particular, the diagnosis made by me and confirmed by Dr. William A. Edwards, of San Diego, who saw the case with me in consultation, and who was present at the autopsy. I quote the following from the report of T. Mitchell Prudden, Professor of Pathology in the College of Physicians, New York: 'The anatomical diagnosis, so far as it can be made from my microscopical and limited gross examination, is: chronic endarteritis and endocarditis; chronic diffuse nephritis, with supervening acute exudative nephritis; congenital cyst of kidney; adenoma of the kidney, probably of supra-renal origin.' The only other point of interest to the profession is the nature and rarity of the above-mentioned adenoma. I will quote again from the report of Dr. Prudden: 'The kidneys show microscopic changes which were alike in both. There were numerous bands of moderately dense fibrous tissue extending from the capsule into the organs, among the lines of the interlobular arteries. New-formed tissue of similar character was present in variously shaped larger and smaller patches. In these bands and patches of fibrous tissue, glomerular tufts and their capsules were converted into dense fibrous nodules; the kidney tubules were atrophied, while in their vicinity the convoluted tubules showed dilatation of the lumen and flattening of the epithelium. In addition to this distinctly chronic process, there were present in both kidneys a marked swelling of the tuft epithelium, and a collection in varying—never very large—amounts of pus cells and granular material and hyalin casts in the renal tubules. The epithelium of the convoluted tubes was not sufficiently well preserved to enable me to ascertain the presence or absence of parenchymatous degeneration. The kidney tumor. Aside from the parts of which are necrotic and which are the seat of hemorrhage, the tumor consists primarily of a series of anastamosing and more or less closely interlacing thin-walled blood-vessels. Some of these vessels are accompanied by a narrow sheath of connective tissue which sends off prolongations on every side; some, on the other hand, are accompanied by a scarcely visible connective tissue investment. This vascular and fibrous tissue forms the stroma of the tumor. The alveolar interspaces between these vessels and connective tissue trabeculæ are of the most varied sizes and shapes, and are largely filled, sometimes loosely, sometimes densely, with polyhedral, often elongated, cells, with large nuclei. Many of these cells contain distinct fat droplets; many are transparent or but slightly granular. They are in places packed together without apparent stroma. On other places, delicate fibrillar projections from the vascular sheaths pass in between them. In sections of the tumor cut in certain directions the large cells, instead of occupying distinct spaces such as are commonly called alveoli, form a distinct investment of the vessels in two or more fairly distinct rows. The tumor is in many places colored by blood pigment as the result of old interstitial hemorrhages. Sections cut through the capsule of the tumor show that although generally closely inclosed by this fibrous investment, the characteristic tumor tissue has formed fresh foci outside its original situations. Sections made through the junction of the kidney and the tumor, show that while intimately joined by the mergence of their respective capsules, the tumor is distinct from the kidney, the latter being squeezed and atrophied where they join, but showing no growth similar in structure to that of the tumor. The tumor, in my opinion, originated either in the supra-renal capsule or in some supernumerary structure of the same nature which may have been originally attached to the kidney or situated outside of it.' " This is Dr. Heydecker's side of the case and it effectually disposes of the presumption that he had in any way questioned or even discussed the opinions that may have been held by Mr. Seligman's former attendant. Mr. Seligman, for some three years prior to his death, had been under Dr. Loomis' care as an office patient. During this time it was recognized that he was suffering from general fibrosis accompanied by an hypertrophied and dilated heart. Recently the patient had become anemic and was in addition suffering from some obscure and painful affection of the jaw, and it was in consequence of these complications that he had been advised to seek rest and a warmer climate. The moral of the tale is that in the discussion of matters medical the newspapers are sometimes a trifle inaccurate.

The Case of Mrs. Martin.

It is very true that "truth is stranger than fiction," and that the incidents of every-day life often transcend in vivid realism the strongest tales of the imagination. This is strikingly illustrated by the Martin case that some weeks ago filled columns in the daily papers. The facts are briefly these: A Mrs. Martin, of New York, who had been suspected of mental trouble of a mild character, one day left her home in an unexpected manner, taking with her her son 5 years of age, and at once disappeared so completely that all efforts on the part of her husband to find the estrays were unavailing. The lady was possessed of ample private means, and aided by an attorney whose conduct in the case seems inexplicable under any circumstances, she successfully eluded pursuit. Her husband made several journeys to Europe, and visited many places on the continent. He traveled to various parts of the United States always to be disappointed, and on one occasion he even made a journey to Australia, only to find that the chase had flown. Finally, after three years of anxiety and suspense, Dr. H. R. Heydecker, now of San Diego, California, but formerly the medical adviser and a friend of the Martin family, by the merest chance encountered Mrs. Martin in an elevator at the Palace Hotel, in San Francisco. The lady had just arrived from New Zealand, and was about to start on another long journey. The following notes of the case, which have been furnished by Dr. Heydecker, are exceedingly interesting: "In the latter part of June, 1891, one of my patients, a lady about 42 years of age, who for a number of years had given evidence of delusional insanity, suddenly disappeared from her home in New York, taking with her her 5-year old son, and leaving behind a husband and a daughter then 7 years old. For more than three years, in spite of every effort to ascertain their whereabouts, this mother and child wandered over the face of the earth, and successfully eluded pursuit. Prior to her sudden departure from home nothing unusual had occurred to lead the family to suppose that she contemplated flight, although for over a year she had imagined herself the subject of persecutions at the hands of her husband. In order to explain how a woman and child could wander about the earth without being discovered, and a father be thus deprived of the possession of his child, it will be necessary to briefly state two or three facts concerning the laws of the State of New York: (1) Other things being equal, minor children of parents not living together belong to the parent who for the time being has possession, and unless the other can cite the possessor before the Supreme Court and show some good grounds, either moral, financial, or mental, why said children should be removed from the custody of the one having them in charge, the Courts will not interfere. (2) An attorney acting for a client not only cannot be compelled, but is absolutely forbidden to reveal the whereabouts of said client against their will. (3) In order to prove to the Courts that the custodian for the time being of the child's person is either morally, financially, or pecuniarily unsuitable for the custody of the child, said custodian must be duly served and cited to appear before the Supreme Court in the county in which they claim residence. From the above it will be seen that unless the wandering mother, who was suspected of insanity, could be found and served, the other parent had absolutely no means of obtaining the person or the care of his minor child. As the mother in this case was possessed of ample means in her own right which, according to the laws of the State of New York, she could dispose of at will, without the knowledge or sanction of her husband, and as her attorney absolutely refused to reveal her whereabouts, the father was effectually debarred from obtaining possession of his child, unless he could find the mother and child, and in some way get them within the jurisdiction of the State and county of New York. This, after three years fruitless labor, was accomplished through my chance meeting with the mother and child in an elevator at the Palace Hotel in San Francisco. As the mother had committed no crime in the eyes of the law, and as in spite of the fact that her mental condition was suspected by all the members of her family, she had not been properly adjudicated insane, I could obtain no assistance from the police authorities, and was, therefore, compelled to rely upon my own ingenuity, and that curse of civilized society the private detective, to retain possession of the person of the woman and child until the father could come from the east and either take possession of his child by force, or induce the mother with the child to travel back to New York. Armed with telegraphic authority from the husband to act in this matter as his representative, I proceeded to devise a plan whereby I might with the least possible notoriety, and the minimum of cruelty, hold the mother and child until the already almost crazed husband should arrive. Thanks to the courtesy of the hotel authorities, and the influence which a reputable physician possesses over his patient, and more than all to the courtesy and confidence of Dr. W. Watt Kerr, of San Francisco, I accomplished this result in spite of the almost insuperable opposition offered to my actions by the agents of the one person who was the gainer by the woman's absence from her friends and her husband. Stating the case to the hotel authorities and to Dr. Kerr, who had been approached and requested to investigate the matter by the other side, I was permitted to have the mother and child kept in their room under guard, on the averred grounds that she was suffering from a mental ailment which demanded complete and absolute rest and freedom from outside influence. The details of the eight days during which I held the mother and child, and the causes which led to my sensational flight from San Francisco, with the subsequent reunion of the parents and children, I will not enter into here, from the fact that they have been so thoroughly described in the daily papers, and also because it is of no interest to the medical profession. My patient being persuaded to return quietly to New York with her husband, a commission was obtained from the Supreme Court to examine into her sanity, and being found a sufferer from delusional insanity due to a chronic inflammation of the cortex, she was by said commission, sitting before the Sheriff's jury, found insane and incapable of caring for her property and her child. A commission for guardian was appointed to administer her estate, direct the care of her person, and determine upon the proper custodian of her children. This was the culmination of my relations with the case, and fully justified the means I had employed in accomplishing this much desired end. Through a two years' connection with the above-mentioned lunacy commissions, as Medical Commissioner in the county of New York, I was enabled, through my knowledge of the lunacy laws of the State, to carry out a difficult piece of medical detective work; and in spite of the numerous disagreeable features, and the still more offensive newspaper notoriety that I was forced to endure, I have been thoroughly compensated for it all by the happy outcome of the case."

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, May 15, 1894.

The President, W. F. WIARD, M.D., in the Chair.

Permanent Quarters and Revision of Fee Bill.—The Committee on Permanent Quarters for the Society and on Revision of the Fee Bill, reported against any effort to procure permanent quarters for the Society at present and until the regular average attendance should be twenty or over. On revision of the fee bill, the committee reported in favor of the adoption of certain specific charges to replace the present general provisions. These fees covered the more common surgical emergencies and were, with some modification, adopted by the Society.

American Medical Association.—The Committee on Subscriptions to the Entertainment Fund of the American Medical Association reported that so far about $350.00 had been collected and that there were yet some members to be seen.

A New Obstetric Forceps.—DR. W. A. BRIGGS exhibited a pair of long and a pair of short obstetric forceps. They were improvements and modifications of those which he had already exhibited to the Society on other occasions. The distal portion of the fenestra of the blades in these instruments had been made solid, and the axis traction attachment had also been simplified. The handle of the forceps had been modified to admit of axis traction when applied to the sides of the head, as well as in the usual manner where axis traction can only be applied with the blades in the axis of the pelvis.

DR. H. W. STRADER read a paper on "Chloroform in Anesthesia," in which the author advocated this anesthetic as more suitable for all cases, more convenient, more certain and, when properly administered, quite as safe as ether.

DR. T. W. HUNTINGTON said the subject of ether and chloroform anesthesia had occupied the attention of surgeons for the past 50 years. Opinions of authorities differed greatly on the questions of safety and of expediency. In the main ether was the safest. In the experience of every surgeon there occurred deaths that were inexplicable unless due to chloroform, as there was no other possible cause. In the *British Medical Journal*, which published the deaths due to chloroform, it seemed as if every number contained a fatality. On the other hand, we rarely see a death recorded as due to ether. In certain cases it was true that death occurred at a later period after ether anesthesia, but these were not recorded. It was urged that special skill was demanded in the administration of chloroform, but this was equally true where ether was used. The speaker used the improved Ormsby inhaler and had found it most satisfactory. In administering ether he had observed that in the later stages of anesthesia, when the breathing at times became shallow and irregular, that by making the initial incision the reflexes were excited and the breathing became rythmical. There was no doubt that chloroform could in many cases be used to advantage.

DR. A. M. HENDERSON: In watching the pulse during the administration of chloroform it is generally thought that the heart stops beating before respiration ceases. The Hyderabad Chloroform Commission, appointed to investigate this point, reported adversely, and stated that the respiration stopped before the heart had ceased to beat, the latter sometimes continuing to act for several seconds.

Dr. W. A. Briggs: Statistics bear out the fact that chloroform is the more dangerous anesthetic. On these grounds I use ether.

Dr. C. E. Fowler said, personally, he had not much faith in statistics. The ratio of deaths due to chloroform was about 1:3000, and it was about the same for ether. You can give either anesthetic with equal safety. As a rule, we give ether indiscriminately, but we select our cases when we use chloroform. The speaker said he had no hesitation in using one or other.

Dr. F. B. Sutliff: I think the A. C. E. mixture is safer than chloroform as it is chloroform diluted. I like chloroform, but I do not use it because it is not safe.

Dr. Thos. Ross: There is no anesthetic that is absolutely safe. Nitrous ether is not adapted for certain operations. Chloroform is used on the continent of Europe and ether in the United States, and this was certainly due to the fact that American surgeons believed it was safer. Statistics were not altogether reliable. Chloroform in operations in children does not irritate the air passages and the child is more quickly anesthetized. Chloroform is also preferable in obstetrics. Lyman's article in Ashurst's Surgery, gives a very slight percentage of deaths from chloroform. Wyeth gives 1:3000 from chloroform and 1:20,000 from ether. Surgeons certainly prefer ether, as the mortality is smaller as compared with chloroform.

Dr. C. B. Nichols: I have watched the ups and downs of ether and chloroform for 23 years. For years I gave chloroform, used it like water, and never had an accident. Any of the deaths reported would have occurred with any anesthetic. The fault may be with the administrator; too much may be given. I do not believe the statistics, as published, are correct. That the patients died from chloroform cannot be proven. Chloroform was not given in Boston because it was a part of the religion of the profession to use ether. During the past five years chloroform is being more used than heretofore. It is the best anesthetic we have, though in cases where it cannot be used ether may be substituted.

Dr. M. Gardner: In almost all the hospitals of Europe they give chloroform. The death rate there is so small as to cut no figure in the case. A very simple inhaler is employed, usually consisting of a clean towel. Inhalers seem to have been generally abandoned on account of their uncleanliness.

Dr. H. L. Nichols: I have used chloroform for 50 years, and it has my preference. I have also used ether, and successfully. I have never had an accident with chloroform, nor have I ever seen an unfavorable symptom. I usually give chloroform on a clean towel or handkerchief. I have had patients under the influence of chloroform for several hours. In Boston men are wedded to chloroform.

Dr. J. H. Parkinson: In looking at the subject in a general way any one will be struck with the fact that all the warm countries favor chloroform, while the colder ones prefer ether. This is probably due to the fact that it is much more difficult to give ether in a warm climate than in a colder one. This must have been repeatedly noticed by all present during the summer. Chloroform is much more convenient than ether in an emergency. It can also be administered with less danger in renal complications and in lung troubles. Regarding rapidity, chloroform can be administered in many ways, ether in one only, and with an inhaler. Given in this manner, and with little air, it is quite as rapid as chloroform. There need be no more struggling with ether if the patient's confidence be first obtained. With little children ether must be given by force, and quickly. With chloroform the element of danger is the chief objection. Patients die when only partially anesthetized sometimes when but a small quantity of the drug has been inhaled. I believe this would not occur with ether. Very few deaths occur during the early stages of ether administration, and while death does sometimes occur subsequent to the administration, it is certainly better for the patient to die in bed than on the operating table. The A. C. E. mixture is certainly safer than chloroform, because it contains less of that drug. Where serious symptoms occur during ether administration, I do not feel the same alarm as if these symptoms came on during chloroform anesthesia. I have never seen a case that could not be anesthetized by ether. Durng administration the ether should be measured, and only a small quantity given at a time. It is true that with ether we have more after-trouble.

Dr. W. E. Briggs: I cannot agree with the views of the author, as I believe that ether should be used in the majority of cases. With an inhaler it can be administered as readily as chloroform, and I have never seen a fatal case. With chloroform I have seen three cases that for a time looked as if they would prove fatal. As a rule I have used ether, and I consider it safer. Enucleation and iridectomy are the only operations on the eye in which it is, ordinarily, necessary to use a general anesthetic, cocain being usually sufficient. I often employ chloroform in operating on children. In Germany chloroform is used almost exclusively, and there they deluge the patient with the anesthetic. In one operation on the mastoid that I witnessed in a Berlin hospital, the symptoms for a time were alarming.

Dr. F. R. Waggoner: In my early pupilage, and up to the time of the civil war, chloroform was in almost universal use. I have used it in a large obstetrical practice. In one patient respiration stopped, but was soon restored. Taking precaution to administer it with plenty of air, allowing the vapor to fall by its specific gravity on the nostrils, I have never experienced any trouble or danger. The hypodermic use of atropine and morphine materially assists in the administration of chloroform.

Dr. H. D'Arcy Power: That there are more deaths from chloroform than from ether does not determine my practice. It is easier to fill a patient with chloroform than with ether. When chloroform is administered properly there is not so much danger. Death is due to carelessness. Too much chloroform is given and the absorption goes on for some little time after. It is purely the result of crowding on the gas. An inhaler is useless. Use a small pad, depending on the gravitation of the vapor. I have twice seen cases where plenty of air and time were required, and the results were very satisfactory. The Hyderabad Commission observed that 1 in 1,330 died where observation was confined to the pulse; none in 45,000 when the respiration was watched.

Dr. G. L. Simmons: The leading American surgeons believe in ether. Ether was discovered in 1846 and used two years before the discovery of chloroform by Simpson, without an accident. I have always given ether and never seen any bad effect. The only death so far in Sacramento from an anesthetic was from the administration of chloroform by two competent men. It gave such a shock to the community that it was impossible to get them to take chloroform, and in private practice we have since always used ether.

Dr. A. T. Piercy, of Benicia: I have been taught that ether is much safer than chloroform, and I have used it. Chloroform is much easier to give than ether. Chloroform is a sharp knife; ether the duller one. Chloroform is equally as safe in competent hands. I give it only a few drops at a time and place the handkerchief to my own nose to test its strength. I have never known of a death directly attributed to ether; have known several cases of deaths from the effects of chloroform. All patients die from chloroform at first and only take a few whiffs. They do not wait until after the operation.

The President: I have used both until the last three years, but now confine myself to chloroform. Looking over the subject and the condition of the patients who die from chloroform, it is evident there is a pathological condition present, and they would have died even if no anesthetic were administered. A great many patients die suddenly, and if an anesthetic had been administered death would be credited to the anesthetic.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, March 17, 1894.

The President, John F. Morse, M.D., in the chair.

Partial Paralysis of Left Oculomotorius and Facial Nerve in Early Syphilis.—Dr. K. Pischl presented a case of partial paralysis of the left oculomotorius and facial nerve in the early stage of syphilis. The patient, a bachelor, 62 years old, had, 30 years ago, venereal ulcers on the penis. Six months ago he contracted syphilitic infection. Since then he often awakes with headaches, complains about rheumatic pains in his back. March 12th, patient noticed that he sometimes saw double; two days afterward the speaker found paralysis of the external muscles of the left eye (which are innerved by the oculomotorius) with crossed double images; two days later the signs of facial paralysis appeared, as could now be seen. [Patient exhibited.] *Status Præsens:* healthy looking man; respiration and circulation normal; urine normal; visible mucous membrane normal. In the sulcus coronarius penis is a hard scar. Glands in the groin and epitrochlear glands swollen, trunk covered with syphilitic roseola. (Dr. D. W. Montgomery, who was kind enough to examine the case, confirmed the above statement.) Right eye normal; left eye drooping, eyeball turned out, movements in other directions impaired. Exact examination of the double images shows the paralysis of the external muscles depended upon the oculomotorius. Pupil reacts well; fundus normal; accommodation not impaired. Mouth drawn to the right, naso-labial fold lowered; the left eye can still be closed and the eyebrows lifted. The case seemed interesting enough to present to the Academy, because we see here an affection of the nervous system in the early stage of syphilis contrary to the cast iron rules of Ricord who contended that the nervous system is only affected in the third stage of syphilis.

Dr. E. Kelly read a paper on "Gangrene of the Scrotum." [Published at p. 393.]

Dr. Dudley Tait: I fully agree with Dr. Kelly as to the rarity of this form of gangrene to the general surgeon, but in the wards of Children's Hospitals it is comparatively frequent, especially after eruptive fevers. This I think is one of the best points to prove that its origin is due to a microörganism. In surgical practice it sometimes occurs as a complication with the old time routine treatment of hydrocele by injection. One case I can bring to mind where the injection of a mild solution of iodine caused a slough. The repair I do not consider as wonderful; there is an abundance of scrotum, too much possibly, and half of it could be resected and no trouble result as to the cicatrix. The cause here in Dr. Kelly's case might have been a phagadenic chancre. I have seen one case where a foul chancre on the lower border of the penis caused extensive sloughing. As to the question of the necessity of castration, Dr. Kelly was right; there is absolutely no necessity for such a proceeding and it would be unsurgical to perform it. I do not know of any instances where it has been done.

Dr. V. Godfrey, United States Marine Hospital Service: I have seen a few cases only. This scrotum certainly looks as it did before the sloughing occurred. This brings me to ask whether or not the peculiar behavior of the destruction of the scrotal tissue does not suggest a special microörganism. After various exciting causes we see the whole scrotal tissue begins to slough, and before we know it is gone, then nature quickly supplies a new one. The sloughing is very rapid and often sets in from apparently no cause. I remember a case where the patient's trouble seemed to be simply malarial; he had a few chills and then the scrotum began to slough. After a herniotomy I have seen sloughing. In that case I would have laid the blame upon the operator and a microbic infection. The question is whether or no a specific microbe may be the *fons et origo.*

Dr. G. C. McDonald: I would like to ask Dr. Kelly what was the calibre of the stricture? A probable and most likely cause might be a slight stricture with an ulcer behind it, a rupture taking place, urine passing through, and scrotal gangrene resulting. This stricture might be overlooked, as a No. 8 or 9 catheter could be passed without detecting it. It is not odd that it sloughs so peculiarly; it is a soft tissue and there is no line of demarcation to cut it off. As to castration, I never heard of such a thing under these circumstances, and I think it would be worse than murder.

Dr. I. Rivas: Three years ago I had a very peculiar case. There was an enormous slough of the scrotum, and from this came out a large stone. There was then rapid and perfect healing, save for a urethral fistula.

The President: In these days of skin transplanting and grafting, and the gratifying results therefrom, there need be no fear of a bad result. As to the question of castration, it should not be considered for a moment.

Dr. Kelly: I would never have thought of mentioning the subject of castration had I not seen statements made concerning it in Bumstead; also in Allen. I cannot see why it was necessary under any such circumstances. In answer to Dr. McDonald, I will state that there was no evidence whatever of urinary infiltration. I had not passed the sound and could not say there was no stricture, but the patient denied all venereal disease. I could not find any evidence of it as the scrotal sac was dead when I first saw the patient. I had to take the patient's word for it. There had been no application made sufficiently strong to cause it. The patient had used a liniment, and as the trouble had set up immediately after that he thought it had been the cause; but on examining it I found it was a very mild ammonia liniment and in all probability had nothing to do with it.

Registration and Segregation in Tuberculosis.—THE PRESIDENT announced as next in order the discussion on the action of certain State Boards of Health in recommending the registration and segregation of tubercular patients, with a view to limiting and preventing the spread of the disease.

DR. W. WATT KERR, in opening the discussion, said: I do not in this discussion refer to the communication of phthisis by meat, milk, heredity, etc., but simply to its communicability from man to man. The majority of the profession are pretty unanimous in the opinion that the disease is communicable. The subject naturally resolves itself into two divisions—communicability and method of prevention. Most men believe the bacillus of Koch to be the cause of tuberculosis; and when we recall the results of experiments and innoculations we are forced to admit the relation between the two. The bacilli of tuberculosis in sputum which has been dried and inhaled into the lungs of a person free from lung trouble, may produce the disease if there is a favorable condition for their lodgment. We, therefore, cannot but recognize the fact of its communicability, and such a fact leads to the discussion of the best method of prevention. Many have proposed a segregation or registration of all tuberculous patients, and hope in this way to control the disease. Such a method would mean a practical ostracism, and is entirely uncalled for. We must look to the prevention, to the life history of the bacilli. It is claimed that we find them in all secretions of tubercular patients, mostly, however, in the sputum. This, then, would lead us to the best methods of rendering the sputum harmless. When first expectorated the tubercle bacilli are enclosed in an albuminous envelope and cannot contaminate the air, such contamination taking place only after the sputum has become dried, is pulverized and mixes with the air. Heat and sunlight are the most efficient destroyers of the bacilli. It is not to be supposed that every one who inhales the bacilli will become infected; it is only when there is a diminished vitality of an organ, or the system in general, from, say a prolonged fever, pneumonia, bronchitis, etc., or overwork or hereditary transmission, that there is danger of infection. To prevent all this shall we segregate these people from all association with the world, or shall we give more attention to the improvement of the general hygienic conditions of all tubercular patients, enabling them by securing an increased vitality to withstand the disease? Suppose that we had a law to segregate all tubercular patients; the expense of carrying it out would be immense. If we isolate a man the State must support him, and so many people have phthisis the drain would be very large. Such a law to have any effect must apply to every one whose sputum contains tubercle bacilli, or has a tubercular deposit in any tissue of the body. Many have the disease and do not know it until it is called to their attention through some other trouble. Every day would bring us new cases. They would come by rail and steamship, and an absolute quarantine would be impossible; the maintaining of such a quarantine would involve an immense outlay, even for medical inspectors. Again, it is not right for us to attempt to practically quarantine tubercular patients, as we would in small-pox or scarlet fever. A person suffering from these is unfit for public duty, but he will be all over it in a few weeks, and as well as ever, while a tubercular patient may live for years, often a greater part of his lifetime providing for himself and others. There is no use in members of the medical profession endeavoring to secure the passage of such a law; if they cannot suggest a better means, it is best that they say nothing. Certainly the profession should give some advice, which if not effective would be at least practical. If the law could prevent and control the disgusting habit of spitting everywhere it would do more good. Make, for instance, the spitting on a car floor a police law instead of a car company's law, and we would check one factor in the spread. Hotels are just as bad. Suppose we had a phthisical case in a room in a hotel, in bed with a lot of newspapers lying about in which to expectorate, as frequently these patients will not use cuspidors. After staying here for a month or so another person, who is run down and generally weakened, occupies the room. Now, as the sputum oftentimes having reached the floor becomes dry and readily inhaled, this newcomer may contract the disease. In such public places and workshops there should be a law compelling all persons to expectorate in a cuspidor containing some germicide, or into a receptacle that could be easily destroyed by heat. We should also teach our private patients to use the cuspidor for the protection of others. The cuspidor's contents to be subjected to prolonged exposure to a powerful disinfectant. The popular idea is that the minute a disinfectant comes in contact with a substance it is disinfected; it is not so, it takes time. In private families we can segregate to a certain extent by warning the rest of the family to occupy separate sleeping rooms, and not allowing any one to occupy a room lately inhabited by a consumptive until it has been thoroughly cleaned, and seeing that the person to occupy it is perfectly healthy. One thing I want to speak of is that in public hospitals phthisical patients have the run of the other wards, or they may occupy the beds next to patients suffering from pneumonia, or some prolonged sickness, which latter circumstance renders the individual a fit subject for tuberculosis. Of course there are cuspidors aud disinfectants, but in such places one has to keep constantly after the patients to enforce the rules. Regarding prisons, there should be laws enacted to secure light airy cells; a long confinement tends to debilitate, and the inhalation of bacilli-laden air proves fatal. Hights of buildings should be regulated nowadays; the tendency is to tall buildings and very narrow streets. These tall buildings tend to prevent a proper dilution of the poisen-laden air below on the streets by excluding fresh air and sunshine, which are powerful factors in health. We should establish plenty of plazas; they are the city's breathing places, and not allow them to become built upon. Impress upon the people that phthisis is very common; that it is infectious; that it is not certainly fatal, and that a proper attention to health will render them immune.

Dr. G. C. McDonald: Years ago the tubercle bacillus was discovered and ever since the profession has been "supposing." I myself do not believe that the inhalation of the bacteria in all cases will cause phthisis. In some cases of phthisis we do not find the bacillus. In those trades where people are exposed to irritating dusts, for instance, they have all the symptoms of the disease and die. I do not say that in all cases the bacillus is not the cause, but I do contend that it is the exception to the rule, and only under certain conditions can the bacillus gain a foothold and set up mischief by a breaking down of the tissue. Regarding segregation, it is not possible to carry this out. First, as Dr. Kerr has just said, the expense would be too great; and then before the medical profession promulgates such ideas it should be very sure of its position, and not make itself the laughing stock of the whole community. In supporting his theory of the contagiousness of phthisis, the speaker quoted at length from a paper on "The Relation of Dusts to Tuberculous Infection," by Dr. G. G. Keron and Dr. F. H. Arnold, which appeared in the *Lancet* of January 6, 1894. The investigations were to discover if the placing of tuberculous patients under certain restrictions would diminish tuberculosis, etc. Guinea pigs were inoculated with dust obtained from various places exposed to infection, and in one case with old dried tuberculous expectoration. In the whole series of 100 animals inoculated only two deaths were due to tuberculosis. One had been inoculated with dust from the main outcast air-shaft of a hospital, into which, in 40 years, 20,000 consumptives had been admitted, and died in 14 days. The other, which was inoculated from the same source, was killed three months after inoculation. Both had grey miliary tubercle in the liver. In another case a nodule developed at the seat of inoculation, but this had no macroscopical appearance of tubercle, nor on microscopical examination could any tubercle bacilli be found. This shaft had not been swept in forty years. So much for experimental research. It is well known that those who attend and nurse tubercular patients do not suffer from that disease beyond the general average. Statistics of Drs. Andrew and Theodore Williams, of the Brompton Hospital for Consumption, show that no special liability could be found among the medical and nursing staff of that institution. Dust is no doubt a factor in the cause of phthisis pulmonalis, but it need not be infected with tubercle bacilli to cause consolidation and breaking down, and all the phenomena of phthisis, as for instance in the trade of the miner, stone, knife and scissor grinder, stonemason, wool and feather sorters, etc., in which dust there is little likelihood of tubercular infection. Let us note that by far the greater amount of tuberculous sputum finds its way on handkerchiefs, diapers, cloths, rags, carpets, etc.; thus preserved it soon becomes dry. We would thus naturally, on theoretical ground, look for an increasing mortality in those who handle, shake and pick over these rags. Furthermore, the papermakers would be very liable to become infected, the rags consisting of old handkerchiefs, diapers, sheets, underlinen, towels and every variety of wearing apparel, some clean and others alarmingly dirty. In the process of shaking, tearing and sorting these, dust is caused so as to completely surround the heads of the pickers, these being young adults, mostly women, and good soil for the bacilli. Dr. Beal, physician to the City of London Hospital for Diseases of the Chest, had the following questions sent to all the medical officers and boards of management of the paper mills throughout England and Scotland: (1) Does tuberculous disease of the lungs or other organs frequently occur in young adults employed in your paper mills? (2) Is there any reason to believe that the dust from the rags is a source of that disease? (3) Are the rags cleansed, wetted or disinfected prior to sorting? (4) Have any cases of inoculation of the skin been observed, presumably due to handling the rags, as tuberculosis or lupus? To all of these inquiries he obtained negative answers. Dr. J. E. Fowler, of Auch Mill, in answer to question four, said that in some instances cases of poisoned fingers occurred, and there had been one case of lupus attacking the lip; Dr. Wilkinson, of King Norton, and physician to Baldwin's immense paper mill, which uses all classes of rags and manufactures all kinds of paper, gave a negative answer to all four questions, and added that during an active practice of 24 years in these mills he had not known of one case of tuberculosis. From Bury in Lancashire, at Wrigley & Sons' paper factory, Dr. W. H. Barr states that during the 20 years that he has been attached to the dispensary and infirmary, together with his observations as medical officer of health for a like period, he has perceived no connection whatsoever between the disease named and the workers in this or any other mill. Moreover, as certifying surgeon under the factory Act, he has failed to notice any connection between tuberculosis and rag pickers in paper mills. He adds that with the daily opportunity he has had and has for observing, such a connection could not have escaped his notice.

Dr. I. Rivas said· None of the gentlemen have spoken of an important point. I refer to marriage between phthisical patients. What influence would this have on the question?

Dr. Dudley Tait: We must admit that tuberculosis is contagious after prolonged exposure and agree that some legal measures should be taken, but any law on this subject would be very difficult to enforce. In yellow fever, for instance, we can quarantine and the patient will not object, but a tuberculous patient would, especially if only in the primary stages. In France since Koch's discovery there have been many devices to prevent the spread. Many hospitals have separate wards. In the French hospital here it was tried, but with miserable success. There are many objections; one is the dislike some patients have to enter such wards or hospitals. In Germany there is a special hospital for consumptives and it is said to diminish mortality in Berlin; but by looking into its real cause it will be found that it results from the exodus of consumptives from Berlin. I believe there should be a better diffusion among the laity of the knowledge of the prophylaxis and general hygienic management of patients. Even if there was a rigid law it would do no good. Take, for instance, the laws governing inspection for syphilis in some countries and you will find that the disease is more prevalent and intense than where no such laws exist. Regarding disinfection, it has been proven that disinfecting liquids in cuspidors are absolutely worthless; excelsior in the cuspidors, which can afterwards be burned, is the best thing. Regarding the remarks by Dr. McDonald, I consider them out of date. Dust will produce death in 50 per cent. of cases anyway.

Dr. McDonald: The notes from which I read are not my own; they simply cover the ground up to February of this year.

The President: The idea of bringing up this subject was to see how the Academy stood on the idiotic action of some Boards of Health regarding prevention by segregation, etc., and was not meant to touch on the contagiousness or hereditary factor of tuberculosis, simply to stamp with our disapproval any such foolish legislation.

Regular Meeting, April 21, 1894.

Suppurative Disease of Knee-joint with Extensive Necrosis of Tibia and Femur.—DR. D. D. CROWLEY, of Oakland, reported the following case and exhibited the specimens. The history gleaned from the patient was as follows: The patient, a woman, middle-aged, came under my care about four months ago, suffering from a suppurating knee joint. Ten years ago, while alighting from a buggy, she fell, and, as she expressed it, she sprained the tendons and muscles at the back of the leg and knee. The knee became swollen and tender; in fact, remained tender for several years, but during this time she could walk very well. Six years after the first accident, she slipped while walking, and fell again. The knee became swollen, and she remained two weeks in bed, after which, and for the next two years she had to walk with the aid of a cane, or sometimes two, as the knee gave considerable trouble from time to time. Two years ago she fell again, and was treated by her physician for a fracture just above the knee. Since the last accident she has been unable to walk without the aid of a cane or crutch. One year ago she said it "pointed" near the inner side of the knee (internal condyle). A physician was called in, who opened it, quite a quantity of pus escaping. Such was the history up to four months ago, when she came under my care. I enlarged the sinus, which was pin hole in size, and irrigated the joint frequently with solutions of boric acid. Reasoning that it might be tubercular, I gave a couple of injections of iodoform glycerin, 10 per cent. into the joint. Two weeks apart, these were followed by a temperature of 103° F. As the patient's general health was poor, and she was greatly emaciated, I resolved, a month ago, to build her up, preparatory to operating by opening the joint and resecting. April 15th, I proceeded to make a semi-lunar incision, convexity downward; exposed the patella and severed it, and in this manner it was easy to reach the joint. I was greatly astonished to find the tibia extensively necrosed and a large cavity extending down into it 2 or 3 inches below the articular surface. A part of the tibia was broken away to ascertain how far the necrosis extended. During this examination a cavity joining the medullary cavity of the femur was found. The question arose as to which would be the proper course; if I removed both sections of bone there would probably be a shortening of seven inches or so, suppuration might ensue and a further operation be necessary; and, at best, the limb would be practically useless. The limb I considered was of no use as it was, and, therefore, I amputated the thigh at about the middle third. I would like to inquire whether it would have been better to remove that portion of bone and wire the femur to the tibia, or do as I did—amputate?

DR. J. M. WILLIAMSON: Taking the history into consideration, and the liability of a prolonged suppuration, the chances of recovery would be below par, and I believe Dr. Crowley pursued the proper course.

DR. LUKE ROBINSON: I think that Dr. Crowley did the best thing that could be done under the circumstances; if he had not done so, he would, in all probability, have had to do a subsequent amputation.

THE PRESIDENT: Resection of the knee is not favorable unless the trouble is localized to the joint.

DR. T. C. RETHERS: I have a very similar case at the present time, and would like to amputate as the best thing to do, but the patient will not submit to it.

Painful and Sympathetic Stump.—DR. CROWLEY: I amputated a leg about two months ago, 3 or 4 inches above the knee, for gangrene, resulting from a fall, that had extended to the knee. The peculiar feature now is that this stump acts as a sort of register for the acts of micturition and evacuation. If the acts are not performed when the desire first comes on, the stump becomes very painful, and during coition, at the moment of ejaculation, the stump becomes very painful, so much so that it renders the act rather agonizing than otherwise. I have never heard of a similar case.

Cholecystectomy.—THE PRESIDENT reported a case of cholecystectomy and exhibited the specimens. Patient, male aged 27 years, native of Bavaria, by occupation a saddler, entered the German Hospital, October 18, 1893. The following is the history: Parents both dead; mother died at the age of 45 years, when patient was quite young; said to have been sickly. Father died at the age of 66 years. Patient; when a boy, was often ailing, so that he had to be kept out of school frequently, suffering from jaundice, for which he had been treated at a hospital when he was 13 years of age. After riding in a race, at the age of 19, he complained of intense pain in the right hypogastrium, which again necessitated treatment at some hospital. At the age of 20 he had another attack of jaundice, with such severe pain that his life was despaired of. His so-called "liver trouble" was sufficient to excuse him from military duty. Since that time he has, at intervals of 6 months to 2 years, been troubled with paroxysmal, intense pains in the right side, always accompanied by jaundice. The paroxysms returned so frequently that the patient had to give up his business of breaking horses and riding. He had never been treated for gall stones, and had never passed any. Quite recently, after taking a quantity of oil, he passed some things which he thought were stones. The attacks of colic grew more frequent, the pains so intense that the patient would writhe in agony upon the floor, and made several attempts to commit suicide by battering his head against the wall. While in this condition the patient was brought to the hospital. He was suffering intense pain in the right side, and was very yellow. He was very weak, and had, upon entering, a temperature of 100.4° F., which dropped to normal on the following morning. On the 20th several small yellow concretions were found in the passages. The pain continued, and on the 23d a hard lump could be distinctly felt rolling under the finger in the region of the gall bladder. Patient was advised to undergo an operation, to which he gladly assented, and, on October 24, 1893, cholecystectomy was performed. The temperature rose to 101.6° on October 30, dropped the following morning, and did not again rise above 101° until November 30, when it fell again to normal. December 17 the temperature rose to 102.6°; patient got very yellow, and felt very badly. An abscess formed, and on the following day a ligature came away and the patient improved. The fistula closed on February 5th, remained closed for three weeks, reopened slightly on March 18th, but closed again the day after. Since then there has been no colic, and only some little stomach trouble.

Large Cysto-fibro-sarcoma of Breast.—DR. T. C. RETHERS exhibited a breast that had been removed that morning from a woman 55 years old. The tumor had been noticed for about 12 years when it suddenly began to grow. The tumor was quite large, weighing five pounds. There was no difficulty in removing it by a large circular incision. A few large arteries were ligated. There was an abundance of skin to close the wound. The tumor was a cysto-fibro-sarcoma.

DR. LUKE ROBINSON read a paper on "William Harvey" [published at p. 416], and presented the Academy with a handsome etching of the distinguished anatomist.

THE PRESIDENT: As President of the Academy I take great pleasure in accepting this valuable etching and in thanking Dr. Robinson for his ever kind thoughtfulness. I hope that it will always be a remembrance of him.

DR. J. M. WILLIAMSON moved that the etching be accepted and that a vote of thanks be tendered Dr. Robinson for his gift. This was carried.

DR. ROBINSON: Harvey was buried in 1657 at Hampstead. In 1882 or '83 the College of Surgeons got permission to remove his remains, and I was present when the body was taken up. It was found wrapped in lead, one corner of which had been oxidized. It was then buried in the College vault. The old boards with arteries cemented on them with which Harvey used to teach the circulation, are now in possession of the College, along with a few books of his library that escaped the great fire of 1666.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular meeting, April 30, 1894.

The President, ALBERT ABRAMS, M.D., in the Chair.

Amebic Dysentery.—DR. J. O. HIRSCHFELDER presented a case of amebic dysentery, occurring in the person of a Japanese, a patient in the City and County Hospital. In January last he began to suffer with abdominal pains accompanied by diarrhea. There were from 6 to 20 evacuations of slimy feces every 24 hours, with tenesmus, each stool being more or less tinged with blood. Physical examination, March 22d, showed the patient to be pale, face slightly puffed, tongue coated white, thoracic organs normal, with the exception of an accentuated second, aortic sound; abdomen tense and sensitive; liver 9½ cm. in mammary line; spleen not demonstrably enlarged. Opium, gr. i every 3 hours, with milk diet, diminished the number of stools somewhat. The stools were examined and found to contain large numbers of amebæ. Injections were then made of sodium bicarbonate, 1 ounce to 2 quarts of water, in the knee-elbow position, using a long terminal. This was followed in half an hour with quinine hydrochlorate, 1:2000, with the result of a considerably diminished number of evacuations in 24 hours, and of the number of amebæ. The tenesmus entirely disappeared. The patient's temperature has not been observed to be above normal. Examination of the blood showed the hemoglobin to be diminished to about 50 per cent. of the normal; urine, sp. gr. 1010, acid, and does not contain albumin. The speaker described the organism and the lesions caused by it in the intestine, reviewing the history of the study of the ameba coli, and referring particularly to the work of Councilman and Lafleur, of the John Hopkins Hospital, on this subject. He demonstrated to the Society the living amebæ on the warmed stage.

DR. L. C. LANE said that in 1855 he had under observation a large number of patients with dysentery, contracted while working on the Panama railroad. He made autopsies on many of them. Numbers of the cases were complicated by liver abscesses. He remembered very well the ulcers in the colon, which closely corresponded to the description given by Dr. Hirschfelder.

DR. J. H. WYTHE said he had under observation at present a case of dysentery in a person who had just come from China. He described the leading characteristics of the principal divisions of the protozoa, and referred to a number of pathogenic and parastitic species. The protozoa which are found to be parasitic in vertebrates are nearly always coccidia or sporozoa. Others are found parasitic in invertebrates. These are nearly all amebic in the earlier stages of their development. In the early days of the microscope, Loevenheuck found amebæ in the kidney of the frog, and Ray Lancaster found them in the frog's blood.

AMERICAN MEDICAL ASSOCIATION.

General Sessions.

FIRST DAY—TUESDAY, JUNE 5.

The forty-fifth annual meeting of the American Medical Association convened in the large Assembly Hall, Odd Fellows' building, San Francisco, Tuesday, June 5th, at 10:45 A. M. The meeting was called to order by the President, JAMES F. HIBBERD, of Indiana, and was opened by prayer, offered by the REV. DR. MACKENZIE, of San Francisco. Through an unfortunate coincidence, GOVERNOR MARKHAM and the LIEUTENANT-GOVERNOR, J. D. REDDICK, were both unable to be present. MAYOR ELLERT, of San Francisco, was also among the absentees, but his place was ably filled by SUPERVISOR J. G. JAMES, who heartily welcomed the Association to San Francisco.

Address of Welcome.—DR. G. L. SIMMONS, of Sacramento, President of the Medical Society of the State of California, next delivered an address of welcome on behalf of the profession of the State. The speaker first reviewed the history of the profession in this State, especially in connection with medical organization. His long residence in California, since 1850, and his early affiliation with medical societies, dating from 1857, fully entitled him to speak on this subject. He reviewed the progress of the profession, and of medicine in California, paying a fitting tribute to those names that had made its early history famous. He referred especially to Logan, Thomas, and the elder Gibbons, as well as to Cooper, the pioneer in medical education. The work of some of these early pioneers had been earnest and painstaking. It had now, in some cases, became invaluable because it was irreplaceable. This was especially true of Logan, whose meteorological observations, extending over many years, were now the basis of the statistics of the Weather Bureau in California.

He alluded to the growth of the Association; to its influence for good, and to the work that it had accomplished in elevating the standard of medical education, predicting for it a field of continued usefulness. In conclusion, while welcoming the Association to California, he said that in every town or village in the State the button of the Association would be an ample introduction wherever its wearer went.

Committee of Arrangements.—DR. R. H. PLUMMER, Chairman of the Committee of Arrangements, presented a report of various matters in connection with the meeting. He stated that there were still some belated travelers from whom he had received telegrams expressing their regrets at being unable to be present, and the hope that they would arrive before the close of the meeting. He gave a brief review of the work of his committee, of the organization of the meeting, and of the entertainments, at the same time presenting invitations from various sources extending hospitalities to the visitors. He then, on behalf of the committee, presented President Hibberd with a handsome gavel; this was made of manzanita root, the handle being of heart of orange wood. Attached to the gavel, on each side of the head, was a gold plate with the President's name on one side and appropriate lettering on the reverse. On behalf of the physicians of Southern Oregon, he then presented a number of gavels made of laurel, one for the Chairman of each Section, which were received for them by the President.

Annual Address.—THE PRESIDENT then delivered his annual address. He first alluded to the change in the date of the meeting from May to June, in order to permit the various State societies to express themselves on the question of revision of the Code of Ethics. The speaker next dealt with the subject of medical organization, in relation to which the constitution of the Association was at present in need of amendment. The constitution called for delegates from subordinate societies, when such societies were represented by delegates in their respective State societies. In many of the States this provision was not enforced, and difficulties consequently arose at the different annual meetings. He suggested that the system in force in Indiana was best fitted to meet the case. Here each county society was represented in the State Society by delegates who alone had the right to vote, and at their annual meeting each society also elected delegates to the American Medical Association, who were then commissioned by the State Society. By following this plan a complete organization of the profession could be effected throughout the United States. The constitution of the Business Committee, as now made up, was considered, in connection with the proposal to confer upon it the functions of the Nominating Committee. It had been urged that this would virtually hand the control of the Association over to the specialists, as the officers of sections were of necessity specialists. The speaker did not take this view of the matter. He regarded the sections as representing the aggregate of all the members present at any annual meeting, and that, therefore, their choice could be of the most representative character. The functions of the sections in relation to officers was only to nominate, and the election or confirmation rested with the whole body of the Association, who could reject if they saw fit. He believed that the Nominating Committee demanded a greater permanence than its organization at present presented.

When Dr. Geo. M. Sternberg was appointed Surgeon-General of the Army one of his first innovations was the formation of an army medical school at Washington, for the purpose of giving passed candidates to the service special instruction in bacteriology, sanitary chemistry, and other branches essential to military service. He also arranged that the position of attending surgeon in cities having special facilities for medical instruction should be filled by young men preparing for promotion. The number of these young men about the larger cities had attracted the attention of the Chairman of the Committee on Military Affairs, who had accordingly provided for the reduction in their number from 125 to 90. When remonstrated with the chairman had stated that no protest had been received from any medical society, but only from the assistant surgeons directly interested. The speaker urged that the Association at once express its opinion on this subject, as, if carried out, this would leave the medical care of the troops at many posts in the hands of the civil practitioners, who, in case of active service, would not take the field, and would thus leave the army deficient in officers who were as necessary to it as any others.

A proposed reduction in the appropriation for the library of the Surgeon-General was mentioned. During the last Congress an attempt had been made to reduce the appropriation needed to complete the catalogue, on the ground that the medical profession was asking too much. This had been saved and the work continued, but a reduction had been made in another appropriation from $10,000 to $7,000, the difference being needed to enable the purchase of books now out of print, and only procurable at private sales. It was a mistake to imagine that the library was maintained for the benefit of the department, or even for the medical profession alone. It was used as a reference library for physicians all over the country, and in this way directly benefited the public. The speaker commended this also to the attention of the Association for immediate action. He then discussed at some length the efforts of the Association towards the establishment of a Bureau of Public Health. As the result of an extended inquiry and a great deal of correspondence he expressed the settled conviction that there was no hope whatever of the establishment of a Department of Public Health within the present century. A Bureau of Public Health with a Commissioner within one of the existing departments might have been within the possibilities, until the powers of the Marine Hospital Service had been so increased, but this had for the present at least put an end to any extension in this direction. In his opinion there was no bill that had been proposed which he regarded as so deserving of support as the bill of the New York Academy of Medicine; and in making this statement he was aware that opposition to this bill had been expressed in quarters worthy of the greatest respect. The speaker referred to the existence of outbreaks of small-pox during the past two years as demanding the unanimous and repeated expression of the profession in favor of the protective power of vaccination. He hoped that the Jenner centennial celebration, provided by the Association as a part of its exercises in 1896, would bring out more clearly than ever the great advantages of this discovery. The necessity of the study of biology was one of the needs of the day. It was through the results achieved by this science that the greatest progress had been made in our science and art. Under its influence medicine had risen more nearly to the level of an exact science, and the whole profession had proportionately advanced in the eyes of the public. One of the purposes of the founders of this Association had been the elevation of the standard of medical education, and he believed that this would be greatly aided by the founding of a Chair of Biology in every school.' In conclusion, the speaker referred to the proposed changes in the Constitution and Code of Ethics of the Association. He said that it was quite evident that the present Code and Constitution was not in harmony with the opinions of a large number of the Association who felt that some changes were needed, the better to adapt it to the demands of modern conditions. On the other hand, there were many members as worthy and as eminent who believed that existing conditions were all sufficient for the needs of the Association. This applied more particularly to the Code about which there was even a stronger feeling of opposition to change. He then outlined a method by a preliminary vote whereby the whole matter might be shortly determined, and expressed the hope that in either event the settlement of the question would be accomplished without passion. The speaker had decided convictions on these questions, but he believed that his position was at present a judicial one, and he therefore refrained from expressing any opinion.

On motion of W. F. BISHOP, of Pennsylvania, a committee of five was appointed to consider and to report upon the suggestions contained in the address. On motion of I. N. QUIMBY, of New Jersey, a committee of five was appointed to prepare resolutions in reference to the proposed reduction in the number of assistant surgeons. The report of the Treasurer, R. J. DUNGLISON, of Pennslyvania, was, in his absence, read by the Permanent Secretary. The Treasurer said that this report represented his seventeenth year of service with the Association, and he regretted that illness in his family prevented him from being present at the meeting. Having alluded to the fact that this absence would create a vacancy, he said that for some time he had been desirous of relinquishing his position, and would now formally tender his resignation. His experience of many years prompted him to make some suggestions for the better conduct of business. He advised the abolition of the rule permitting delinquents to retain membership for two years, which, since the publication of the *Journal*, had often given rise to complications. He believed that this could be now reduced to one year, so that members in arrears could be dropped, and simultaneously cease to receive the *Journal*. The list of members should be published every year, as soon as possible after each annual meeting. His experience had been that any increase of membership that may occur through additions made at the annual meetings, even in the most successful years, were almost always extinguished before the close of the fiscal year. Had it not been for the system of membership by application, adopted several years ago, there would be little or no permanent annual increase in the membership of the Association. He therefore hoped that this feature would be carefully fostered. In conclusion, he said that the work of the Treasurer was yearly becoming more onerous, and he believed that he should receive a salary commensurate with his important duties. On motion, the report was received and placed on file, and that portion referring to needed legislation was referred to the Business Committee.

W. B. ATKINSON, of Pennsylvania, as Permanent Secretary, read his report of the action of the State Medical Societies regarding a change in the Code of Ethics. Twenty-one societies were opposed to any change; two were in favor of a change; two laid the subject on the table; and of the remainder, some took no action on the matter, and the others had not, so far, made any report. C. A. L. REED, of the Committee on Pan-American Medical Congress, requested further time to present his report, which was granted.

THE CHAIR then announced a recess of twenty minutes, for the delegates from the different States to select their representatives on the Nominating Committee. The Secretary, on reconvening, read a list of names, to which there were subsequently several additions. The greatest number of votes cast at any meeting of the Nominating Committee was 39; the whole number of states and territories represented being 39. The Business Committee being incomplete, the officers of the various sections were instructed to appoint alternates from the members in attendance. The Association having voted Dr. Dunglison its hearty and unreserved thanks for his efficient and laborious duties as Treasurer, then adjourned.

SECOND DAY—WEDNESDAY, JUNE 6TH.

The Association was called to order by the President at 12 M. After the usual report by the Chairman of the Committee of Arrangements, in which additional invitations were presented, I. N. QUIMBY, of New Jersey, on behalf of the Committee on the Proposed Reduction in the number of Assistant Surgeons, presented the following resolutions, which the Permanent Secretary was directed to communicate to Congress by telegraph:

Resolved, That the American Medical Association urge upon Congress the advisability of preserving and promoting the efficiency of the Army Medical Department.

Resolved, That any reduction in the present membership of the Army Medical Department would be prejudicial to the interests of the army and the country.

Address on Medicine.—The address on Medicine was read by C. H. HUGHES, of St. Louis, who had taken as his subject, "The Nervous System in Disease and the Practice of Medicine from a Neurotic Standpoint." The speaker briefly mentioned the advances of medicine through preventive inoculation, beginning with vaccinia, and predicted that within a comparatively short time consumption, with a mortality of 165,000 in this country alone, would have become a thing of the past through judicious antisepsis. Modern surgery had also made wonderful strides, both in the management of affections of the abdominal cavity and in the treatment of brain lesions. He proposed in this address to direct the attention of the Association to some points in the practice of medicine from the standpoint of a neurologist. He first dealt with *la grippe*, which he characterized as a toxic neurosis, explaining its varied effects by the impression created on the nervous system. Some of the complications and sequelæ were identical with those produced in animals by section of the vagus and he saw in this an explanation of effects not otherwise possible. The disease was now generally recognized as a very grave one. It generally so weakens the nervous system as to permit all the tendencies to disease or the latent symptoms of former trouble to declare themselves. The disease was too often made light of, whereas it was, in its immediate and remote effects, one of the gravest of maladies. The author also classed dyspepsia as a brain disease. It occurred, as a rule, not amongst the hard workers, but rather amongst the brain-workers and he who worries, eating but little and exhausting his nervous system. The brain influences the stomach and the stomach the brain, but the power of the former over the latter was far greater. In this conclusion it was not necessary to ignore any fact in chemico-biological research. The investigations of Beaumont on the stomach of Alexis St. Martin had conclusively proved the power of mental influences on the digestive processes. No better illustration of the potential relation of the nervous system to disease could be mentioned than hysteria. This condition, illustrated in a most forcible manner from the standpoint of clinical observation, how suddenly and how extensively all the organs in the body may be profoundly disordered by a morbid impression through the nervous system. The tropho and vaso-motor neuroses were legion and of the most opposite character. Referring to the fact that the nervous system regulates the law of rythm in the animal economy, he said that a clearer knowledge of this fact would often give hints and therapeutic suggestions for the management of our patients that were overlooked in practice. The importance of the early recognition of neurasthenia was dwelt on. The speaker regarded this condition which he had termed "neurathropia" as a disturbance of the brain, characterized by timidity of conduct, nervous irritability and morbid fears, bordering on, but not becoming delusions, and physically by functional atony of the viscera, especially of stomach, heart, bowels, and motor and psychical areas of the brain. The speaker next touched upon the relations of neural overstrain to the development of cancer and consumption. He believed, as he had stated many years ago, that a break down in the nervous system by which its trophic and resisting power is lessened, makes possible and precedes all cases of cancer. This was equally true of consumption, as it provided the necessary soil in which the bacillus could thrive. There had been a great advance in the recognition accorded to the influence of the nervous system on dermatological troubles, and results might be looked for as this truth became more evident. What was true of the stomach and lungs was also true of the heart, and it was evident that certain diseases of that organ came from states of the brain. That the neuropathic source of hemophilia was in the vaso-motor system is more probable than any asserted dycrasia of the blood. Cholera is so largely a condition of nervous prostration in its symptomatic expression, that we are more apt to save our patients by sustaining the nervous system than by the adoption of any other plan. He did not mean that this excluded any other treatment, but it was the damage to the nerve centers that we wished to guard against until the collapse stage had passed. The normal temperature of the body is regulated by the nervous system, and in like manner any derangement of temperature depends upon the action of some irritation, chemical, mechanical, or toxic, upon the nervous system. The influence of the nervous system upon the liver and the secretion of bile was well established. Leukemia was another of the conditions that resulted from profound nervous exhaustion or shock. Rattlesnake poisoning was an example of a profound impression on the nervous system, often killing very rapidly and without perceptible structural lesion. The nervous system is the supreme ruler of the organism and whatever view we may take of bacilli, bacteria, or cocci, disease becomes manifest only after the mechanisms of neural sensations, emotion, ideation, or control reveal it. A change in. the weather or a certain exposure sends one man to bed with rheumatism, another with pneumonia, and a third comes down with remittent fever or phthisis. We say uric acid in the first case, pneumococci in the second, malaria in the third, and tubercle bacilli in the fourth. What is that vitality that permits one man to withstand climatic changes and to resist an infected atmosphere? We have invented, for evasive answers, certain elucidating terms as idiocyncrasy, diathesis, organic tendencies, but the true reply lies in the diminished control of the nervous system. The speaker closed a very eloquent if rather lengthy address, with a review of the progress of medicine in its relation to man, his well being, his commercial, and his social progress. He predicted that in the future medicine and the physician would take a rank far higher than that of any other profession. "Should men contest the claim of medicine to being the greatest of the world's benefactions, we reply: The germ theory of disease causation alone, with its applied antagonisms, hygiene, antisepsis, perfect cleanliness, and resistive and tolerant inoculations has done, is doing, and is yet destined to do, more for the physical welfare and salvation of mankind than all other causes of man's comfort conceived in the mind and heart of man."

H. O. **Marcy**, of Massachusetts, offered the following preamble and resolution, which was referred to the Business Committee: *Whereas*, This Association has long recognized the advantages to be had from the more intimate relation between the State Medical Societies and the American Medical Association; it is hereby

Resolved, That we request the various State Medical Societies to perfect their local organization so as to include, as far as possible, in the membership of their district societies every regular practitioner within the State. That these local societies shall actively coöperate in urging a general attendance upon the annual meetings of the State Societies; that the date of the same be so fixed that it shall not interfere with the attendance of those members who are delegates and members of the American Medical Association, in order that a general unification of the interests of the medical profession of America be promoted, and the American Medical Association become, in a yet higher degree, the exponent of the profession; that we also request the State societies to unite in establishing a uniform standard of professional requirement for admission to the practice of medicine, and to aid, as far as possible, in advancing the scientific status of the same by the appointment of State Examining Boards, independent of the teaching faculties of the Medical Colleges. To this end, we further direct that the Permanent Sécretary of the American Medical Association enter into correspondence with the Secretaries of the several State Medical Societies, and furnish, annually, a written report of the membership of the State Societies and the working effectiveness of their organization.

The report of the Librarian, G. W. **Webster**, of Illinois, was, in his absence, read by the Secretary, and was referred to the Business Committee. Having briefly reviewed the terms of the transfer of the library of the Association to the Newberry Library of Chicago, which had been ordered by the Association at its last meeting, the deposit to be made permanent as long as the books were properly cared for, he said he had ascertained that the Trustees of the Newberry Library absolutely refused to accept the books unless they were made a permanent deposit without reservation. He therefore submitted an agreement which embodied the feature of permanency, and provided that while the books and pamphlets should be treated as the property of the Newberry Library, they should be so marked as to show that they belonged to the collection received from the American Medical Association. This regulation should also apply to all books and pamphlets which are deposited with the Library.

E. E. **Montgomery**, of Pennsylvania, then read the report of the Board of Trustees. Having congratulated the Association upon safely weathering the financial depression of the past year, he stated that, after paying all bills, the treasury of the Board showed a balance of $1,885.10. Notwithstanding the successful management of the board, the speaker said that it had been unable to escape criticism, and that at this meeting the Judicial Council had been asked to censure it for its conduct in publishing questionable advertisements. Nothing had presented greater difficulty to the Board than the decision as to what should be considered proper matter for the advertising department of the Journal. In reaching a decision, they had been guided by the general rule that no advertisement would be inserted which would not also appear in the *British Medical Journal*, the *Boston Medical and Surgical Journal*, the *New York Medical Journal*, the *Medical Record* and the *Medical News*. At a former meeting the attention of the Trustees was directed to the fact that the Code of Ethics prohibits all commendatory mention or advertisement of proprietary preparations, and instructed them to respect this prohibition in the conduct of the Journal. The Board had complied with the letter of the law in demanding the formulæ of all proprietary remedies, but, being legally responsible for the financial obligations incurred, it had felt compelled to accept certain advertisements and to trust to the sense of justice of the Association in relation thereto. The speaker paid a high tribute to the energy and earnest efforts of the present editor, Dr. J. B. Hamilton, and, in closing, called attention to the fact that the post-office had decided that the Journal was not entitled to entry as second-class matter, unless the annual dues of the Association could be termed subscriptions to the Journal. He therefore recommended that hereafter the $5.00 annual dues shall be divided, apportioning $1.50 for the general expenses of the Association, and $3.50 as the annual subscription to the Journal; to non-members the subscription should be $5.00 *per annum*. A motion to receive and adopt the report was made, when Edward Jackson, of Pennsylvania, moved to amend by substituting that it be received; that thanks be tendered the Trustees; that their suggestions be adopted, "but that the Association does not approve of the policy of the Trustees with regard to advertisements." The amendment was laid on the table, and the report was then adopted. The proposed Constitution was made a special order for 10:30 A. M. on Thursday, and the Association then adjourned.

THIRD DAY—THURSDAY, JUNE 7TH.

Report of Committee on Revision of Constitution.—The Association having been called to order, H. D. HOLTON, of Vermont, Chairman of the Committee on Revision of the Constitution, read the report of the majority of the committee. This report was, in substance, similar to that which has been published in THE MEDICAL TIMES during the past year. Several changes had, however, been made; the most important being an apparent abandonment of the hybrid Nominating Committee, consisting of the Business Committee, plus representatives from the different states and territories as now selected, and the retention of the present method alone. A further provision was made, that affiliated societies would be entitled to one delegate for every five of its members, and one for every additional fraction of more than one-half of that number. Any member having served for two years as a delegate would henceforth be entitled to vote at all annual meetings, the voting power, as at present, being reserved to the delegates.

H. D. DIDAMA, of New York, read the minority report, which retained the present representation by delegates, the present formation of the Nominating Committee, and, while expunging a great deal that was now unnecessary amongst the various resolutions, adopted, combined and retained that which was most essential in these resolutions and in amendments that had been, from time to time, embodied in the present constitution.

Both reports having been submitted to the house, E. D. FERGUSON, of New York, moved that the minority report be substituted for that of the majority. This precipitated a rather irregular debate, in which many members wanted to talk at the same time, some even making a feeble attempt to do so. The Chair having stated that the adoption of this motion would simply present the minority report for consideration, the excitement calmed down, and, a vote being taken, the motion was adopted by a vote of 160 to 70. G. F. JENKINS, of Iowa, then moved that the, now majority, report be accepted and adopted as a whole. There is no doubt whatever that this motion could have been carried, but the audience was fast becoming excited, and those to whom the fortunes of the minority report had been confided were decidedly "rattled." The confusion was increased when BERGSTEIN, of Nevada, moved to amend, "that the Constitution and amendments be read and considered, section by section, in comparison with the present Constitution." This suggestion which would obviously occupy the two remaining sessions without, perhaps, arriving at any conclusion, was met with a storm of dissent, amidst which Dr. Bergstein's powerful voice could be heard protesting that he was not an obstructionist, but simply wished to have some clear idea of what he was voting upon. His admission that he had never read the present Constitution restored general good humor, and the amendment was defeated, 158 to 100. There were many present who seemed anxious to participate in the debate, and a resolution by H. P. NEWMAN, of Illinois, that no one should speak more than once on the subject, and only for three minutes, the mover of a resolution to have five minutes, was promptly adopted. W. E. QUINE, of Illinois, took the platform, and in a very forcible speech opposed the adoption of the minority report. He made the usual statements, that the present Constitution of the Association was responsible for its slow growth and limited membership, and that a more liberal policy, which, however, was not defined, would result in gathering in the 100,000 physicians in the United States to form one grand association.

Comparisons were drawn between the British and the American Medical Association, in which the former was credited with a membership of 20,000. Other statements were made of an equally unreliable character, but the presentation of the speaker's case was good. X. C. **Scott**, of Ohio, spoke in favor of the minority report, and he was followed by **Marcy**, of Massachusetts, **Jackson**, of Pennsylvania, and **Ferguson**, of New York, who endeavored to indicate the importance of the changes in the minority report, and the grave disasters that would result from the adoption of the document presented by Dr. Holton. J. W. **Graham**, of Colorado, moved to lay the whole matter on the table. This was promptly voted down, 128 to 84. **Scott**, of Ohio, then moved the previous question. The ayes and nays were demanded, and a roll call was ordered. This consumed a great deal of time, and it was soon evident that the roll, as presented, was not free from errors. The names of some were called who were not delegates, while others who were delegates, and in attendance, were omitted. This was subsequently explained through the fact that on the first day an accurate record of delegates was not maintained at the Registration Bureau. The total vote cast was 215; ayes, 151; nays, 64; necessary to carry, 154. **The Chair** declared the motion lost. E. D. **Ferguson**, of New York, then offered as an amendment to the by-laws to insert the words, "annual subscription to the Journal of the Association," for the words "annual dues", wherever it might occur. This was to cover the point raised by the Trustees in connection with the entry as second-class matter of the Association Journal. The motion was adopted unanimously, and the Society then adjourned until Friday morning at 10:30. There is little doubt that the minority report as a whole could have been adopted at this session, had there been better management on the part of those supporting it. So much confusion had been created by the various speakers, motions and amendments, that at times but few knew exactly the question that was being voted upon. Dr. Ferguson is entitled to credit for endeavoring to make these clear by questioning the President as to the result of a vote about to be taken, a course in which he persisted most perseveringly, in the face of considerable protest from the opposition. Notwithstanding this, however, many of the western men were led astray, and it is reasonable to suppose that the necessary three votes could have been obtained had the matter been put more directly.

FOURTH DAY—FRIDAY, JUNE 8TH.

The Association was called promptly to order by the President, when the Chairman of the Committee of Arrangements had something to say about transportation matters, as well as a word about the excursion on the Bay. J. B. **Roberts**, of Pennsylvania, then moved that all amendments to the Constitution and By-laws, now on the table, be postponed until the next meeting, which was adopted.

The report of the Committee on Revision of the Code being now in order, H. D. **Holton**, of Vermont, came forward and faced the largest audience that had yet assembled, while he read some of the "reasons" that had induced the majority of the committee to present the report, or rather the proposed Code that had already appeared in the Association *Journal*. The speaker quoted Marion Sims and Oliver Wendell Holmes, and very forcibly presented his side of the question, at times in pathological and figurative language. This committee desired "to avoid all reference to medical sects and irregular practitioners, because such reference sullies the dignity of the Code, and because it is a recognition of the existence of that which we believe should not exist, and because it is the most efficient means of perpetuating the objectionable condition." The speaker closed amidst hearty applause; and H. D. **Didama**, of New York, the faithful minority of one, came forward and read his report. This, which had been presented by the speaker at Milwaukee, and which has already appeared in The Medical Times, still remained as his mature conviction upon the subject. He said: "A careful examination of the revised Code, as published in the *Journal*, had only served to confirm the opinion he had already expressed. He did not desire to occupy valuable time by pointing out the omissions from, alterations of and additions to the Code, which have received the signatures of the majority committee," but still very forcibly and earnestly he pointed out some of the more glaring of these. Certain varieties of advertising formerly condemned were actually commended by the revision, and he had no doubt that many of his hearers had read "with surprise and grief" the statement "that the possessor of a license granted by a Board of acknowledged legal authority should not be refused consultation when requested by a patient." In closing, the speaker said: "Some of you of your own free will and accord and as loyal representatives of State societies, which have spoken with no uncertain sound, undoubtedly hold the opinion that legality and fitness are not interchangeable terms. Notwithstanding the ingenious arguments of the eminent gentlemen who constitute the majority committee, you are not convinced that consultations of regular physicians with irregular practitioners are proper or beneficial to the patient. The irregular may be honest and sincere. He may have received a collegiate education. He may be a pillar in the church. He may thoroughly know anatomy and chemistry and biology. He may be able to speak with the persuasive tongue of eloquent men and of angels. And yet if he, by ignoring or rejecting the rational materia medica and therapeutics, upheld by all regular physicians throughout the world, and professing to be governed in his practice by a metaphysical dogma, demonstrates that he and the regular doctor have absolutely nothing of any practical importance in common, some of you steadfastly believe that a pretended consultation in these circumstances would be, even if the patient desired it, an imposition and a swindle which no sophistry can rectify, no plea of liberality palliate, no fee recompense or excuse." The speaker retired amidst applause that fairly indicated in which direction the voting strength of the meeting lay.

E. Fletcher Ingals, of Illinois, caught the President's eye, and moved to lay the minority report on the table. This was promptly rejected, and X. C. Scott, of Ohio, moved that the minority report be substituted for that of the majority. This was carried by a substantial vote, and the announcement of the fact by the Chair was a signal for an effort at recognition by many speakers. It was quite evident that the same condition of affairs that occurred during the progress of the debate on the proposed Constitution was now inevitable. The supporters of the minority report were divided as to the best course to pursue, and, mistrusting their strength, were afraid to risk a vote on its adoption. On the other hand, Dr. Ingals, who appeared to lead the opposition, was camped at a convenient distance from the minority supporters, and with a copy of "Robert's Rules of Order" in his hand, was not to be caught napping. It was strongly urged, by those who believed they knew the temper of the meeting, that a decisive vote be taken on the adoption of the report. But the "minority" was too faint-hearted, possibly realizing how much they had at stake, and yet forgetting that even defeat on this motion left them the opportunity to defeat a motion for the adoption of anything else. It was therefore decided that the best course to pursue was to move the indefinite postponement of the consideration of the report. This motion having been reduced to writing by the mover, was then offered, and was seconded by Scott, of Ohio. His voice was, however, not heard by the general assembly, while that of Holton, of Vermont, sitting in the front row, who at once rose to second it, was heard all over the hall. The motion was received with loud murmurs of dissatisfaction from every direction, but especially from the extreme right of the hall, where the greater number of the California delegates were sitting. These expressions were heard, and probably misinterpreted, by the "minority," who were attacked with paresis at the action of Dr. Holton, the Chairman of the majority, in seconding their motion. Evidently there was something horribly wrong here, and the confusion was not diminished when Ingals, still holding fast to his "Rules of Order," said: "You have made a mistake. This motion is not as strong as mine." There was a short pause, and then, amidst the rising murmurs from all sides, the minority leaders asked the mover of the resolution to withdraw, which he attempted to do, naming Dr. Scott as his seconder. This was disputed, but the Chair granted the request, and the motion was withdrawn, amidst mingled laughter and disapprobation. Dr. Ingals then put his motion to lay on the table, which was adopted, 135 to 30. This ended the question of the Code for the present session, and the comments on the action of the supporters of the old Code were rather severe. It is very evident that here in the house of its friends, and with every certainty of adoption, the report of the minority was needlessly sacrificed. There was hardly a delegate from California who desired any change, nor one who would have permitted it as long as it was possible to vote against it. The instructions of the State Society, and of many of the local societies were so positive as to leave no discretionary power. It was simply a case of want of confidence, and an opportunity was lost to California of definitely recording herself as opposed to sophistry and fraud in the conduct of every-day professional life.

The report was received and adopted without any very marked enthusiasm.

EDWARD JACKSON, of Pennsylvania, offered the following preambles and resolution: WHEREAS, The *Journal of the American Medical Association* has continued to publish unethical advertisements, like those of "Antikamnia," "Labordine," and other secret nostrums, and that of the American Physicians' Sanitarium Company, offering one hundred dollars' worth of stock to physicians sending it to patients; and whereas, the Trustees of the *Journal* have defended such a course on the grounds that the money from such advertisements was needed to publish such a journal as they thought creditable to the Association, *Resolved*, That the various State Medical Societies in affiliation with this Association are hereby requested to inform this Association whether their members approve the policy of admitting such advertisements to the pages of the *Journal of the American Medical Association*.

The speaker explained that he took this action because he was so instructed by the Pennsylvania State Medical Society, and he reminded the Association that he was the representative not only of the largest State Medical Society, but also of that one showing the largest proportion of members in relation to constituency of any in this country. He had endeavored to bring this matter up at a previous session and had been defeated, and he now brought it forward in the hope that members would see the matter more clearly. There was a good deal of feeling displayed even on the part of some adherents to the "new Code at any price" party. X. C. SCOTT, of Ohio, moved to lay the matter on the table, which was defeated, 113 to 102. It was very evident that the sentiment was strong on this question and many members were canvassing the situation in their seats. Those who were opposed to the obnoxious advertisements were uncompromisingly so in their opposition, while those on the other side were not very hearty in voicing their opinions. There were several speakers, amongst whom the editor of the *Journal* was prominent. Then DR. C. H. HUGHES, of Missouri, took the floor to state that he had no connection with the obnoxious sanitarium company, from which he had at once resigned on ascertaining its nefarious character. He appealed in winning accents to the Association not to embarrass its Judicial Council, and inquired in guileless tones why it should not be treated with confidence and respect. Then, in an emphatic manner, he asserted that this Council had summoned before it the Board of Trustees, implying that said Board already dreaded the fate that was in store for it. Several people seemed to have heard of Antikamnia, though one speaker who said "every physician used it," was greeted with a loud murmur of disapprobation. It was, however, evident that this unethical product had friends in the house, and the Chairman of the Committee of Arrangements was smiling blandly on the audience as he held in his hand an Antikamnia Visiting List, from which he had just been reading to the Association. Some one then explained that Dr. Jackson was mixing up two questions, which, if separated, could soon be decided. The preambles really related to the action of the Judicial Council, while the resolution was independent of their action and could be adopted independently. Finally the resolution was referred to the Judicial Council, the preambles having been stricken out.

It was very generally felt that the action of the Association, or rather of the opposing parties, in declaring a "draw" on the question of revision of Constitution and Code, was very unfortunate, leaving, as it did, a heritage of trouble for Baltimore. The situation was certainly not good and it was decided to make an effert to remedy things. H. O. MARCY, of Boston, who, when President of the Association two years ago, had appointed the now divided committees, after a brief speech, moved to take from the table all matters pertaining to the Constitution, By-laws, and Code of Ethics. The supporters of revision were, however, suspicious, and the motion was only adopted by a narrow majority, 100 to 91. Dr. Marcy then moved to indefinitely postpone the whole matter, and the motion was carried without a dissenting voice. Most people breathed a sigh of relief, the more sanguine congratulating themselves on the fact that the matter was settled, at least for some years, but Ingals, who, in reply to the inquiry "where are we at?" had said, "just where we were before, ready to begin again;" added that Banquo's troubled spirit was not laid, and it seems evident that "the ghost will walk" at Baltimore or at some subsequent meeting.

Dr. W. T. Bishop, Chairman of the Committee on the President's Address, made the following report: The Committee to whom was referred the address of our President, James F. Hibberd, M.D., LL.D., Richmond, Indiana, respectfully reports: The change of date from May to June, 1894, is approved. Credentials might be issued in duplicate, one copy given to delegate, and one copy or list of delegates, with power of substitution, forwarded to Secretary of American Medical Association, and he to furnish list of recognized bodies to Committee of Registration, the effort to be, as the President suggests, to get all members of the regular practice into the American Medical Association through State and county societies. With the President we cannot approve the turning of the Association over to the control of the Sections; the Sections should remain as they are and have their own officers, etc., as now provided for, the Nominating Committee representing men who are in the general or special practice of their several States and counties, are sure to select proper officers, having done it for fifty years, the Association not being bound to accept the officers named, having the power to amend the report of the Nominating Committee or refer it back for correction. The American Medical Association should invite the attention of the Congress of the United States of America, as represented in the Senate and House of Representatives, to the fact that we are opposed to the reduction of medical men from 125 to 90, or any other number less than at present provided for, 125 assistant surgeons; let the officers of our Association and the officers and members of State and county societies at once act; this is a matter of great importance to the army and the country at large. The appropriation to index catalogue and library should be increased, as before the proposed reduction, to $10,000. The whole profession in this country, as well as Europe, are interested in this subject. We urge the continuous effort for the Department of Public Health, but recognize that if organized, it, like bills organizing State Boards of Medical Examiners, will either lack much that we desire or contain much that we do not desire. We want a Department, and can repair or improve it afterward. This last may take time, and all will require some money to secure what we wish—the money and labor, etc., now spent must be secured by further effort. The effort should be made at all times to promote vaccination and establish proper sanitary conditions—the physician in his daily practice has much to do with preventing disease; the large population that is "on the move" makes it necessary that every good citizen should be on guard to prevent the spread of disease and crime. Since our last meeting some States have provided for a Board of Medical Examiners, who will examine all who come into their State to practice medicine; the Board to be composed of members of the profession, but not connected with any teaching institution. The medical profession and the world at large require from the practitioner more than ever before, knowledge founded upon education. The microscope and the cultures of the investigator make certain what was once surmised. The attention is called to the constant amendments that are being offered to the Code and Constitution, and the members are warned to avoid ill feeling in the discussion of these questions. The address in general is most heartily approved.

The report was adopted. The language of the report, however, is not quite clear where it says: "With the President, we cannot approve the turning of the Association over to the control of the Sections." The impartial reader will rather hold that the President decidedly approved of that course and argued in support of it.

L. Duncan Bulkley, of New York, as Secretary of the Business Committee, presented the following report:

The Business Committee recommends to the Association the adoption of the accompanying resolution of Dr. Marcy, which was referred to it. It also recommends the adoption of the agreement with the Newberry Library of Chicago in regard to the transference of the Library, with the alteration made upon it that the future deposit of books, etc., be optional with the Association and not obligatory. The Committee also recommends the adoption of the following resolution in regard to the issuing and printing of the official program for the annual meeting:

Resolved, That the official program containing the appointments for the general sessions and the work of the sections shall be printed at the office of the *Journal* of the Association, and in order that this may be accomplished, the officers of the sections and the Committee of Arrangements shall transmit the program of the business and scientific proceedings so that it shall be in the hands of the Permanent Secretary of this Association at least one month before the date of each annual meeting. The list of entertainments shall be prepared by the Committee of Arrangements, and, as far as practicable, shall be included in the official program.

The Business Committee also ask if they are empowered to receive business directly from the sections before it has been presented to the Association, and if such is not included in their present authority, ask that the same be granted, as it believes that much time will thus be saved, and the work of the Association forwarded. The Business Committee, to which was referred the suggestions contained in the Treasurer's report, recommend as follows: (1) That the Constitution be amended in that portion relating to the necessity of electing to office only those who are present at a meeting, so that the Treasurer be not thus included. (2) That the Treasurer receive compensation commensurate with the services required of him, and recommend that three hundred dollars ($300) be appropriated for that purpose. The third suggestion, regarding delinquency in the payment of dues, the Committee consider has been already met by the change in Constitution passed yesterday, so that no further action thereon is necessary. The Committee recommend that the Board of Trustees appropriate $300 for the salary of the Permanent Secretary. The officers for the ensuing year are: Chairman, Dr. E. E. Montgomery, Philadelphia; Vice-Chairman, Dr. J. M. Duff, Pittsburg; Secretary, Dr. L. Duncan Bulkley, New York.

The report was adopted by the Association.

The Address on Surgery and that on State Medicine were read by title, the authors being absent and neither having seen fit to send his address. This rather discourteous course should be prevented in future. The addresses are a prominent feature of the meetings, and the selection of the person to deliver them is an honor highly valued, and it should not be lightly treated. At the present session it would have been difficult to find time for these papers, as the full limit of the session was always occupied with the various matters under discussion.

Jerome Cochran, of Alabama, the Chairman of the Nominating Committee, presented its report, the following being nominated as officers for the ensuing year:

President.......... Donald McLean, Michigan.
First Vice-President.......... Starling Loving, Ohio.
Second Vice-President.......... Wm. Watson, Iowa.
Third Vice-President.......... W. B. Rogers, Tennessee.
Fourth Vice-President.......... F. S. Bascom, Utah.
Treasurer.......... H. P. Newman, Illinois.
Permanent Secretary.......... W. B. Atkinson, Pennsylvania.
Assistant Secretary.......... Geo. H. Rohé, Maryland.
Librarian.......... (election passed.)
Place of meeting.......... Baltimore, Maryland.
Chairman Committee of Arrangements...... Julian J. Chisholm, Maryland.
Board of Trustees: Jos. Eastman, Indiana; J. T. Priestly, Iowa; D. W. Graham, Illinois (full term); J. E. Woodbridge, Ohio (unexpired term); J. W. Graham, Colorado (*vice* D. C. Patterson, deceased).
Judicial Council: D. W. Crouse, Iowa; R. C. Moore, Nebraska; T. D. Crothers, Connecticut; G. B. Gillespie, Tennessee; W. T. Bishop, Pennsylvania; C. H. Hughes, Missouri; I. J. Heiberger, D. C.; H. Brown, Kentucky (unexpired term).
Address in Medicine.......... W. E. Quine, Illinois.
Address in Surgery.......... C. A. Wheaton, Minnesota.
Address in State Medicine.......... H. D. Holton, Vermont.

X. C. Scott, of Ohio, moved that the Trustees be instructed to publish every other week in the Association *Journal* the explanatory declaration relative to the Code of Ethics [*vide* pp. 19 and 20 of Code]. This was received with some derision by the revisionists, who said the speaker was blowing hot and cold in opposing revision and in requesting the publication of this matter. It was suggested that the clauses mentioned be published every issue, and the resolution passed in this shape.

Amendments were offered to the Constitution, one by **Quimby**, of New Jersey, striking out the words "surgical instruments or" from Section 5, Article 9. These were laid over.

The Special Committee appointed to petition Congress to create a Department and Secretary of Public Health, of which C. G. **Comegys**, of Ohio, was chairman, presented its report. The work of the committee during the past year was reviewed and progress reported. In endeavoring to secure the passage of the bill already submitted to the Association the committee encountered strong opposition from the Chief of the Marine Hospital Service, who believed it encroached upon the functions of his office, as director of quarantine affairs. The apprehension of the entrance of Asiatic cholera, and the consequent strengthening of the quarantine service, rendered it inadvisable to make any further effort during that session. In September, 1893, the bill was brought before the Pan-American Medical Congress, and the Committee on State Medicine recommended its adoption, there being only one dissenting voice. The committee concluded that in order to avert the opposition of the Marine Hospital Service it would be wise to reconstruct the bill, leaving out any reference to the supervision of the quarantine service. The bill, as re-drafted, had been introduced at the present session of Congress. The success of the bill had been greatly compromised by the action of the New York Academy of Medicine in its endeavor to frustrate the Association by pushing bills of its own, which proposed to keep the profession under the autonomy of either the Secretary of the Treasury or of the Secretary of the Interior. In conclusion, the speaker said that it was not probable any bill could pass at this session of Congress, but the Association should be ready to make the most powerful effort possible at the next session. In consequence of ill health Dr. Comegys tendered his resignation. The committee offered the following resolutions:

Resolved, That the American Medical Association renews its appeal to the Congress of the United States to adopt the bill now in its possession for the creation of "A Department and a Secretary of Public Health."

Resolved, That the committee proceed as soon as possible to secure sub-committees in each congressional district of the country to obtain a favorable action on the part of their Senators and Representatives for this measure.

Resolved, That a committee be appointed to endeavor to secure the friendly coöperation of the New York Academy of Medicine.

Resolved, That a sum not exceeding four hundred dollars be appropriated to defray the necessary expenses of the committee in carrying on their work.

The report of the Committee appointed by the American Medical Association to act in conjunction with a Committee of the American Public Health Association, was, in the absence of the Chairman, U. O. B. **Wingate**, of Wisconsin, read by **Jerome Cochran**, a member of the Committee. He said: The Committee had met with the American Public Health Association and had found that there was, on the part of that body, a disposition to take no further action in the matter. It was impossible to convince the members of the two Committees that no lesser office than that of Secretary of Public Health in the Cabinet of the President should be encouraged. The following resolution was therefore submitted, and was adopted by the American Public Health Association, as a compromise between the two factions of the Joint Committee:

Resolved, That the American Public Health Association again urge upon Congress the necessity of the appointment of some officer with general sanitary authority in connection with the national government; That the functions of such an authority are of sufficient importance to demand the exclusive attention of the best instructed sanitarian; That such authority should be enabled, from time to time, and under proper regulations, to secure the advice and coöperation of the State Boards of Health.

Dr. **Cochran** presented a communication from the Medical Association of the State of Alabama, which is also the State Board of Health, strongly favoring the passage of the bill now before Congress, and suggesting the insertion of a clause providing for an annual conference of State Boards of Health at Washington. On motion of **Chas. Denison**, of Colorado, the reports were received, the addition proposed by Alabama accepted, the resignation of Dr. Comegys, as

Chairman, accepted, and Dr. Cochran appointed in his stead. The section on State Medicine presented resolutions in relation to the death of JOHN H. RAUCH, of Illinois, which were concurred in by the Association. The Section on Materia Medica and Pharmacy, presented the following resolutions, which were, on motion, adopted:

Resolved, That the American Medical Association directs the attention of the medical colleges of this country to the general neglect of the study of botany by medical students, and that it is the sense of this Section that the teaching of general descriptive botany should be made a part of the curriculum of study in every medical school. The delegates present at this meeting from the American Pharmaceutical Association concur in this action.

Resolved, That the American Pharmaceutical Association be invited to contribute to the *Journal of the American Medicial Association* reports of and examinations of proprietary and secret nostrums, made under its direction. The officers of the Section on Materia Medica and Pharmacy to act with a committee to be appointed by the American Pharmaceutical Association, as a Committee of Conference in order to carry this resolution into effect.

The Secretary read the following list of officers nominated by the various Sections, to serve during the ensuing year:

Practice of Medicine—Chairman, E. W. Kellogg, Milwaukee, Wis. Secretary, W. E. Quine, Chicago, Ill.

Surgery and Anatomy—Chairman, Joseph Ransohoff, Cincinnati, Ohio. Secretary, Reginald H. Sayre, New York.

Obstetrics—Chairman, F. H. Martin, Chicago, Ill. Secretary, X. O. Werder, Pittsburg, Pa.

State Medicine—Chairman, L. H. Montgomery, Chicago, Ill. Secretary, C. H. Sheppard, Brooklyn, N. Y. Executive Committee, C. A. Lindsley, New Haven, Conn.; H. S. Orme, Los Angeles, Cal.; J. J. Kinyoun, Washington, D. C.

Dermatology and Syphilography—Chairman, A. E. Regensberger, San Francisco. Secretary, D. H. Rand, Portland, Oregon. Executive Committee, L. D. Bulkley, New York; L. A. Duhring, Philadelphia; A. H. Ohmann-Dumesnil, St. Louis, Mo.

Dental and Oral Surgery—Chairman, M. H. Fletcher, Cincinnati, Ohio. Secretary, E. S. Talbot, Chicago, Ill.

Ophthalmology—Chairman, Edward Jackson, Philadelphia. Secretary, H. V. Würdemann, Milwaukee, Wis.

Neurology and Medical Jurisprudence—Chairman, Daniel R. Brower, Chicago, Ill. Secretary, W. J. Gavigan, San Francisco, Cal. Executive Committee, John W. Givens, Blackfoot, Idaho; T. D. Crothers, Hartford, Conn.; A. E. Regensberger, San Francisco, Cal.

Laryngology and Otology—Chairman, J. F. Fulton, St. Paul, Minn. Secretary, T. J. Gallagher, Pittsburg, Pa.

Diseases of Children—Chairman, Edward H. Small, Pittsburg, Pa. Secretary, Geo. W. McNeil, Pittsburg, Pa.

Materia Medica and Pharmacy—Chairman, W. L. Whelpley, St. Louis, Mo. Secretary, George F. Hanson, San Francisco, Cal. Executive Committee, F. Woodbury, Philadelphia; F. E. Stewart, Watkins, N. Y.

Physiology and Dietetics—Chairman, E. H. Woolsey, Oakland, Cal. Secretary, Chas. G. Chaddock, St. Louis, Mo. Executive Committee, I. N. Love, St. Louis, Mo.; W. T. Bishop, Harrisburg, Pa.; Ephraim Cutter, New York.

The nominations were confirmed by the Association.

The business of the meeting having been concluded, DR. R. H. PLUMMER, the Chairman of the Committee of Arrangements, now came forward to make his final report. He said that the attendance had far surpassed the expectations of his committee, about 1,200 delegates, visitors, and ladies having registered. The success of the meeting had been most gratifying, and he heartily thanked all for their presence in San Francisco.

DR. H. D. HOLTON then offered the following resolutions, making some very flattering remarks, while congratulating Dr. Plummer on the very successful results of his efforts:

Resolved, That the most cordial thanks of this Association are due and are hereby tendered to the profession of California, the medical societies, the citizens of San Francisco, the Directors of the Midwinter Fair, the railroad officers, and all who have so generously contributed to make our visit to the Pacific

Slope successful, pleasant, and a memory that will live to cheer us during all our lives.

Resolved, That the thanks of the Association are hereby tendered to the President, Secretary, and other officers who have contributed to make this one of the most successful meetings in the history of the Association.

The resolutions, which were seconded by DR. H. O. MARCY in similarly complimentary terms, were unanimously adopted.

THE PRESIDENT then appointed DR. HOLTON and DR. L. C. LANE as a committee to escort the President-elect, DR. DONALD MCLEAN, of Michigan, to the chair. Dr. Mclean, on being presented to the Association, spoke in very feeling terms of the honor conferred upon him, and sincerely hoped that he would see all here present at Baltimore. Some one then moved to adjourn, but PRESIDENT HIBBERD, in his own inimitable way, said the motion was premature, as he himself had a speech to make. He then complimented the members upon their exceedingly good behavior, thanking them for their kind consideration towards the Chairman, and added so easy had been the task that he would not mind doing it every year.

The Association then adjourned to meet in Baltimore on the first Tuesday in June, 1895.

THE ENTERTAINMENTS.

As soon as it was definitely announced that the American Medical Association would hold its meeting of 1894 in San Francisco, it was generally felt that the visitors should be entertained in a manner commensurate with the reputation of the State. It was early determined that no contributions should be solicited from sources outside the profession, and a systematic canvass of physicians throughout the State was undertaken by the Committee of Arrangements. Societies and individuals were solicited to contribute, and as a result of this and of the generous liberality of the State and of the San Francisco County Medical Society ample funds were raised. Entertainments were given by members of the profession, by the medical colleges, and by professional organizations. Every one seemed satisfied, but it would be out place for us to more than indicate the nature and character of each, leaving to our visitors the judgment of the result.

On Monday evening, June 4th, an instrumental concert was given at the headquarters of the Association, Palace Hotel, by Noah Brandt's orchestra. Many of the travelers who had been delayed on belated trains had arrived, and the occasion was one of general reunion.

Tuesday afternoon the visiting ladies were given a drive through Golden Gate Park, along Ocean Beach, and home by the Cliff House and Presidio. A very large number of the visitors availed themselves of this occasion to see the beauties of the park and ocean, and the carriages, when ready to start, made a most imposing cavalcade.

In the evening the San Francisco County Medical Society gave a reception at Pioneer Hall, which was so largely attended that the capacity of the building was taxed to its utmost, and the commissariat completely exhausted. Owing to the arrangement of the building every one was enabled to enjoy himself as he pleased. In the large hall dancing was kept up till a late hour. In the upper rooms where the State Mining Bureau's collection of minerals is displayed, members congregated to discuss the weighty affairs of the Association, and we are informed there was also a "place" downstairs where an efficient and hospitable committee welcomed all who came.

On Wednesday the time was pretty well filled, in fact it was impossible to assign separate hours for all. In the afternoon the Ladies' Reception Committee gave a "Tea" at the residence of Mrs. R. A. McLean, whose beautiful home was crowded with the visitors.

That evening Cooper Medical College received the Association. The college building with its magnificent auditorium and the Lane Hospital, now almost completed, were thrown open to all who came. The dissecting room was too much for some of the visitors, though far less odoriferous than such places usually are. For over three hours a most thorough inspection of the premises was in progress, the hospital in particular coming in for a large share of attention. Early in the evening Dr. Lane, the President of the College, as well as its founder and constructor, delivered a brief address, giving some details of the work that had here been accomplished in the cause of medical education. The absence of Dr. N. S. Davis, who had been detained at home in consequence of sickness in his family, was universally regretted, but more especially on this occasion, as it had been arranged to make it a demonstration of the feeling of the profession for his efforts in behalf of medical education.

During the evening a reception was given to the Association by Dr. W. F. McNutt, at his residence 1805 California street. Nothing was spared to make the entertainment fitting to the occasion. Music was provided for dancing, and the large number of young people present made the evening scene a gayer one than the larger and more informal reception of the night before. Dr. McNutt's contribution to our hospitalities was certainly most generous and effective.

Thursday morning it had been arranged that the ladies should visit the Midwinter Fair, but as the Association was down for the same event that evening many of the ladies visited points of interest in the city, some of them taking in the sights in Chinatown.

During the afternoon and early evening Mrs. L. C. Lane received the Association and a number of visitors at her residence, corner of Clay and Buchanan streets.

At 8 P. M. several hundred people left the Palace Hotel bound for the Midwinter Fair. The grounds were illuminated and all the buildings open. In every direction could be seen the button of the Association, and the visitors very thoroughly inspected the displays in the various departments. Horticulture and Mining, the two most important sections, coming in for most attention. At 10 o'clock light refreshments were served in Festival Hall. Here again the demands by the unexpected attendance were greater than could be supplied, and the refreshments were soon exhausted. On first assembling in the hall there was some speechmaking, but of an informal character, everything being brief and to the point. The electrical display was very fine, both tower and fountain being in operation. The evening was unusually fine; the fog failing to interfere with the festivities.

On Friday afternoon Mr. Adolph Sutro, whose daughter and son-in-law are members of the profession, entertained the ladies at Sutro Hights. Luncheon was served in the new Pavilion of the Sutro Baths, an orchestra being present throughout. Mr. Sutro was an excellent host and acquitted himself well when replying to a vote of thanks unanimously tendered by the guests.

In the evening the Medical Department of the University gave a reception at the Hopkins Art Institute, which, being the property of the University, was obtained for the occasion. The beautiful mansion was illuminated throughout and the scene, during the evening, was a very brilliant one, the large central hall, and indeed all the rooms, being thronged with visitors. There was again a shortage in the commissary department. One of the hosts said he had provided for 800 people, but it appeared as if twice that number had come. However, all were good humored, and the lighter refreshments held out till the last.

On Saturday, June 9, the profession of California, through the various medical societies gave an excursion on the bay, which was of a most enjoyable character. The steamer Newark, of the Southern Pacific Company, one of the largest and the fastest steamer on the bay, had been chartered for the occasion, and Noah Brandt's orchestra furnished good music to all who enjoy such a treat. Refreshments were served at ten o'clock and at any hour thereafter during the day, it being understood that the vigorous atmosphere of the water would "conduce to appetite." Having visited all points of interest around the lower bay and after making a short trip toward the Gate, the steamer headed for Mare Island, where everyone landed and made a hurried inspection of the navy yard and naval hospital, and some ships of the new navy, including the coast defense vessel Monterey. On reëmbarking, the vessel was pointed for home, and on the trip down the bay speech-making and singing beguiled the time. Warned by the generous attendance at previous entertainments, the Chairman of the Committee had provided amply in the matter of refreshments while the manner of serving them allowed all to have enough in comfort. No hitch occurred during the day and every detail seems to have been most carefully looked after, the visitors expressing their most hearty appreciation of the occasion of their visit to the coast, as well as their determination not to again remain so long away.

During the meeting there were several entertainments of a private character. Amongst these were a breakfast given to the Section on Obstetrics and Diseases of Women, by the San Francisco Gynecological Society, at the Baldwin. The Annual Dinner of the Sections on Ophthalmology and Laryngology took place on Wednesday, at the California Hotel. Dr. H. M. Sherman gave an "orthopedic dinner," to which some of the surgical fraternity were also invited. There were other and smaller entertainments, every one endeavoring to contribute his share to the general good fellowship.

CORRESPONDENCE.

The Tuberculin Test for Tuberculosis in Cattle.

Dear Sir: During the latter part of last May some experiments with the tuberculin test were made at the dairy of the State Insane Asylum at Stockton, to which considerable public interest was drawn, and which caused some alarm among people in general, and dairymen in particular, with regard to the prevalence of consumption among the dairy cattle of the State and the danger of communication of the disease through milk. The experiments were made at the direction of the President of the State Board of Health by a veterinary surgeon, who injected the tuberculin in eleven animals which, with the exception of three, had at some time showed symptoms of disease. The temperature was taken in the rectum every hour for about 24 hours following the inoculation. Six out of the eleven animals showed a rise of temperature of 3.5-7° F. eight to fifteen hours after the injection. Three animals gave no fever reaction to the test. From this it was concluded by those making the experiments that six out of the eleven animals were tuberculous. Five days after the injections had been made an autopsy was held on two of the cows, which had reacted to the test with a temperature of about 105° and 107° F., respectively. The first cow showed a general tubercular infection of the lymph glands about the neck, thorax and abdomen, and of the serous membranes of the pleural and peritoneal cavities, the latter being covered with numerous miliary tubercles. In the second cow the infection was not so general, nor was the fatty degeneration so far advanced as in the first; nodules were found in lungs and liver, but the peritoneum was free. The germ of tuberculosis was found in the tubercles of the lungs. Three weeks after these autopsies had been made, one of the large bulls of the asylum, a very large, fat and healthy looking animal, which had reacted to the tuberculin test with a temperature of over 105° F., was killed. The animal commenced to show symptoms of disease a week after the inoculation, and as its horns had been sawed off about this time its sickness was ascribed to this. A careful *post-mortem* examination was made, but not a trace of tuberculosis was discernable in any part of the body. A large abscess was, however, found under the skin, covering a large part of the shoulder of the animal and extending up the neck and down the leg to the knee. The center of the abscess answered to the point of insertion of the needle in making the injection of tuberculin. The results of the experiment at Stockton do not, therefore, as far as three of the eleven animals are concerned, speak very highly for the reliability of the tuberculin test. It might be a question whether the method employed would account for the rise of temperature in an animal which afterwards proved to be free from tuberculosis, as it was not confined to strict antiseptic precautions; no cleansing of the skin was made where the animals were inoculated, nor was the syringe sterilized after each injection. The amount of tuberculin injected was 20-30 gtt., according to the weight of the animal, which some writers consider quite large, four drops being sufficient to stimulate the tuberculous tissue into activity and cause a notable rise in temperature. The reports of experimenters with the tuberculin test differ greatly. Some have reported the test to be infallible, "without a single failure," but many others have met with varying results. Thus, Pang injected 53 animals, in 41 of which the *post-mortem* examination disclosed tuberculous disease. Of these 41, 38 gave a typical reaction; in three the reaction was insufficient. Of 12 healthy animals two gave a very insignificant reaction. Lyttin injected 80 animals selected at random. Of these 18 showed reaction, of which 17 were found tuberculous. Roeckl and Schultz injected 60 animals, with a positive result in 51. Of these, 43 were found tuberculous. Of 15 animals with a negative result, four were found with the evidence of the disease. The *New York Medical Journal* of June 9, 1894, contains an excerpt from the German journal, *Hyg. Rundschau* (February 15, 1894), giving the results of an experiment by Dr. Rievel, as follows: Six heifers were bought for experiment. Of these, three reacted to tuberculin injections, their temperatures being thereby raised from 1.8° to 4.8° F. These three seemed tuberculous, and were therefore slaughtered. Careful expert veterinary examination revealed in two of them acute bronchial catarrh, but neither tubercles or bacilli. In the third heifer (not the one that showed the highest temperature) a few bacilli were demonstrated in tubercles found in the lymph glands. From these, and another similar experience, the inference is drawn that tuberculin is not uniformly reliable as an indicator. The results of Roeckl and Schultz are similar to which is claimed to be an average of the results with the tuberculin test, namely: that in nearly 15 per cent. of the cases giving a positive result no tuberculosis is found, while in the animals that give no reaction about 10 per cent. are found to be tuberculous. The question, whether the tuberculosis may be communicated by injection of the meat of the tuberculous cows is most probably to be answered in the negative. Dr. C. G. Currier writes in the *New York Medical Journal* of June 9, 1894, that red flesh of tuberculous cattle is not apt to carry the infection, the blood being quite free from infecting bacilli. In the case of pork from a tuberculous pig the danger seems to be greater. Sajous' "Annual of the Universal Medical Sciences for 1893" (vol. I, A 12) reports some experiments by Dr. Perroncito, who thoroughly investigated the possible danger from the ingestion of the flesh of tuberculous animals. He inoculated two hundred rabbits, as many guinea pigs, and two oxen, with the fluid obtained from the muscles of tuberculous pigs. None of these animals became tuberculous. Eighteen young pigs were fed for a period of four months with the flesh of tuberculous cows. On *post-mortem* examination of these animals no tubercuculous lesions were found. The report says, in conclusion: On the whole, then, there seems to be but comparatively little danger in this direction. With regard to the communicability of milk from the tuberculous cows, expert opinions differ widely. Some hold that no danger of infection therefrom exists, provided the udder is not obviously diseased; others condemn milk from an animal that is distinctly tuberculous in any organ. The latter, says Dr. C. G. Currier (June 9, 1894), a writer on practical hygiene and sanitary science for the *New York Medical Journal*, seems the safer opinion to be guided by, yet exceedingly few unquestionable cases can be adduced in support of it. Cooking kills disease germs. None of the bacilli of tuberculosis remain alive in meat or milk exposed in every part to a temperature of 175° F. for more than ten minutes. The discussions on the subject of tuberculosis in cattle and the tuberculin test as a means of diagnosing the disease, can but be productive of a great deal of good by calling the attention of the public to the importance of having dairies clean, not over-crowded or ill-ventilated, and the dairy cows healthy, so as to insure a supply of good milk. To let the reaction to the tuberculin test be a criterion, independent of physical symptoms, as to whether an animal should be slaughtered or not, is, however, a step in advance of the present status of medical science. It is to be hoped that the test will, in course of time, prove to be an infallible one, although the injection of tuberculin would appear to afford the most valuable means, so far at our disposal, for detecting the disease in latent cases; yet at present the unbiased observer, who has carefully considered the unfavorable as well as the favorable reports, can not regard himself as justified in condemning an animal which has given a reaction to the tuberculin test, unless such animal, upon careful examination, presents some physical symptoms of the disease.

I am, etc., A. W. HOISHOLT, M. D.,
Physician State Asylum for Insane, Stockton, Cal.

OBITUARY.

OBED HARVEY, M.D.

On the 17th of January, 1894, there was removed from our midst a man who, by natural endowments, education, experience and extended acquaintance, had found a place that few of us may hope to reach. Than DR. OBED HARVEY few men in the State were better known or more generally liked. As a friend or public servant he was sincere, wise, unfaltering and determined. In him every worthy man found a helper, and every worthy cause an advocate. As a legislator, his enlightened sense of right and duty was his constant guide, and no man, however close the ties of friendship or however exalted his position, could swerve him from the course thus indicated. While for many years his time and attention were mostly demanded in the management of his investments, he always took a lively interest in medicine and its progress, and kept well abreast with those who followed the profession exclusively as a business. With the exception of his own family, consisting of a devoted wife, son and daughter, perhaps his loss was most keenly felt at the State Insane Asylum at Stockton, which institution for many years had been favored with his services as a Director. When Dr. Harvey was called away many felt, and must continue to feel, an irreparable loss.

A. C.

JOHN MILTON BRICELAND, M.D.

DR. JOHN MILTON BRICELAND was born at Holliday's Cave, in what is now West Virginia, in 1825, and received an academic education in Western Pennsylvania. He graduated at Jefferson Medical College, Philadelphia, in 1847, practising two or three years in North Carolina, and then removed to Texas, where he practised until 1859, when he came to California and settled in Shasta, where he continued to reside and practise until his death, May 24, 1894. He was chosen to represent his district at different times in both the Assembly and Senate, acquitting himself with the highest honor. He was a profound thinker and eloquent debater, and one of the most popular men in northern California. He served for a number of years on the California State Board of Health, and was in charge of the Shasta County Hospital for sixteen years, up to the day of his death. He loved the study of his profession, but for some years past, on account of failing health, avoided, as much as possible, the responsibility of practice.

S. M. M.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held June 13, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

Milton Harris Atkins, San Francisco; Coll. Phys. and Surgs. Chicago, Ill., April 3,'94.
Miles Racey Biggar, Los Gatos; Detroit Med. Coll., Michigan, February 28,'83.,
James W. Brown, Grass Valley; Chicago Med. Coll., Illinois, March 20,'77.
William M. Bullard, Helena, Montana; Indiana Med. Coll., Indiana February 25,'76.
Stephen P. Cavanaugh, Petaluma; Cooper Med. Coll., California, December 7,'93.
S. Chaffin, Santa Maria; Med. Dept. Univ. of Mich., June 30,'92.
R. Edmond Dixon, San Luis Obispo; University of Virginia, July 1,'91.
J. Dave Edmundson, San Francisco; Missouri Med. Coll., Missouri, March 0,'88.
William J. Edmundson, San Francisco; Med. Dept. Univ. Tennessee, February 23,'82.
Dora Fugard. Los Angeles; Woman's Hosp. Med. Coll., Illinois, April 2,'89.
Hattie J. T. Hilton, Los Angeles; Med. Dept. Univ. of Michigan, March 26, '73.
Isaac M. Houston, San Francisco, St. Louis Coll. of Phys. and Surgs., Missouri, March 8,'89.
William Jenner, San Francisco; Univ. of Munich, Germany, July 29,'72.
Barton Williard Johnson, San Jose; Barnes Med. Coll., St. Louis, Missouri, March 20,94.
Francesco La Spada, San Jose; Coll. of Phys. and Surgs., Chicago, Illinois, April 3,'94.
James Francis McCone, San Francisco; Med. Dept. Univ. of California, December 13, '92. Lic. Royal Coll. Phys., London, January 25,'94. Mem. Royal Coll, Surgs., England, February 8,'94.
John K. McLennan, Nipoma; Univ. of Manitoba, Canada, April 20,'94.
Orlando W. Newell, San Francisco; Univ. of Iowa, Keokuk, Iowa, February 26,'57.
William M. Ogden, Tropico; Harvard Univ. Med. School, Mass., March 7,'66.
Florence Botsford Power, Sacramento; Willamette Med. Coll., Oregon, April 4,'93.
R. C. Stockton Reed, Santa Fe Springs, Cal.; Cincinnati Coll Med. and Surg., Ohio, Feb. 16,'60.

Albert Bird Royal, Pasadena; Rush Med. Coll., Illinois, February 21,'77.
B. C. H. Spencer, Los Gatos; Michigan Coll. of Med., Michigan, March 3,'81.
H. B. Stanly, Sutter City; Med. Dept. Univ. of Oregon, April 2,'88.
Gottlieb Stein, Los Angeles: Coll. Phys. and Surgs. Univ. of Berlin, New York, March 1,'75
Germany, January 26,'84
Franklin Stuart Temple, Berkley; Albany Med. Coll., N. Y., April 27,'92.
Robert Frank Wallace, Biggs; Med. Dept. Univ. Tennessee, February 26,'86.

Certificates were refused to the following named: Norman M. Avery, Stockton; G. W. Covert, Long Beach; LeRoy F. Herrick, Stockton; N. M. Howard, Selma. Oliver L. Jones, Stockton; Annie Wilder, Chico, Mary E. Williams, Benicia.

CHAS. C. WADSWORTH, Secretary,

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from May 20 to June 20, 1894.

First Lieutenant Charles Willcox, assistant surgeon, will report on June 6th, proximo, to the commanding officer of the cavalry camp at Vasquez Canyon, near Gilroy, California He will return to his proper station Angel Island, California, when his services are no longer required in the field. Par. 1, S. O. 57, Dept. of California, May 31, 1894.

Captain William L. Kneedler, assistant surgeon, will accompany Batteries B and M, 5th Artillery, hence to Fort Canby, Washington, as medical officer, and will return from that post with the two batteries of the same regiment en route to the harbor of San Francisco, in the same capacity. Par. 2, S. O. 58, Dept. of the Columbia: June 1, 1894.

Lieutenant-Colonel Albert Hartsuff, deputy surgeon-general, during the temporary absence of Assistant Surgeon Kneedler, will perform his duties in addition to those of medical director of the department. Par. 3, S. O. 58, Dept. of the Columbia, June 1, 1894.

The telegram from these headquarters of the 2d instant, granting one month's leave of absence, on surgeon's certificate of disability, to First Lieutenant Frank T. Meriwether, assistant surgeon, Fort Logan, Colo., with permission to leave the limits of the department, is hereby confirmed; the case being urgent, special action was essential. Par. 2, S. O. 31, Dept. of Colorado, June 6, 1894.

Captain E. C. Carter, assistant surgeon, will proceed without delay to camp of U. S. troops at Snake river bridge, Idaho, and report to the commanding officer for duty. Par. 1, S. O. 97, Dept. of the Columbia, June 14, 1894.

Second Lieutenant Fred W. Sladen, 14th Infantry, will proceed without delay to camp of U. S. troops at Snake river bridge, Idaho, and report to the commanding officer for duty with his company.

The following named officer, having been found by army retiring boards incapacitated for active service on account of disability incident to the service, is, by direction of the President, retired from active service: Lieutenant Colonel Samuel M. Horton, deputy surgeon-general.

Major James C. Merrill, surgeon, is relieved from duty in the office of the surgeon-general, to take effect July 1, 1894, and ordered to report in person to the commanding officer, Fort Sherman, Idaho, for duty at that station.

Leave of absence, for three months, to take effect July 1, 1894, is granted Major James C. Merrill, surgeon.

Promotion.—First Lieutenant Phillip G. Wales, assistant surgeon, to be assistant surgeon with the rank of captain, June 7, 1894, after five years service, in conformity with the act of June 23, 1874.

ITEMS.

Dr. Jas. K. Simpson has removed from Juneau, Alaska, to Ricton Ontario, Canada.

Dr. D. McC. Gedge has removed from Los Gates, to 406 Sutter street, San Francisco.

Dr. W. P. Burke has removed from 1003 Clay street, Oakland, to Lytton Springs, Sonoma county, Cal.

Dr. Minnie G. Worley has removed from 1108 Sacramento street, to No. 5 Prospect Place, San Francisco.

The Archives of Pediatrics, commencing with the July issue will be edited by Dillon Brown, M. D., Adjunct Professor of Pediatrics at the New York Polyclinic.

Dr. D. D. Crowley, of Oakland, left for Europe on June 3d. The doctor expects to spend most of his time in Edinburgh and in Paris He will be abroad until the latter part of September.

The Address of Dr. S. Weir Mitchell, to the American Medico-Psychological Association, with appended letters from prominent neurologists, will appear in the July issue of the *Journal of Nervous and Mental Disease*; the author's name will command the interest of all physicians.

Craig Colony for Epileptics.—The legislature of New York State has passed and the Governor signed the bill establishing a Colony for Epileptics in that State. The Colony is named after the late Oscar Craig, President for some years of the State Board of Charities. The bill provides for the purchase of a tract of 1,875 acres of beautiful land in the Genesee Valley, near Mount Morris, in Livingston County. The law requires that all buildings put up should be on the village plan. A Board of five Managers is provided for, and the following have been appointed: Dr. Frederick Peterson, of New York; Mrs. C. F. Wadsworth, of Genesee; Geo. M. Shull, of Mount Morris; Dr. Chas. E. Jones, a homeopath, of Albany, and W. H. Cuddeback, of Buffalo. At their organization in Albany, on the 3d of May, the Board of Managers made Dr. Fred. Peterson, of New York, President, and Geo. M. Shull, of Mount Morris, N. Y., Secretary, of the Board. Dr. Peterson, who has written so much on epilepsy, is well qualified for the position to which he has been elected. It is, however, not at all clear why the Governor should have made up his board of a lawyer, an editor and a homeopath.

Occidental Medical Times.

Vol. VIII. AUGUST, 1894. No. 8.

TWO CASES OF UNCLASSIFIED INFECTION.

By W. F. Arnold, M.D., Passed Assistant Surgeon, U. S. N.

Read before the California Academy of Medicine, May 19, 1894.

On March 11, 1894, I attended an autopsy at the request of Surgeon John W. Ross, U. S. N., the medical officer who had had charge of the patient; but as I had no intimation as to the nature of the illness of the deceased, and as the time and place were not favorable to this end, the autopsy was not a complete one, and the records that were made beside the table were not all preserved. The weights, for instance, of the various organs removed do not appear; but my impressions, confirmed by some of those present, are against any striking abnormalities in this direction.

The following account will embrace the material contents of the official records of the case, supplemented by the observations which its unusual features led me to make:

Rigor mortis was characteristically developed at the time of the autopsy, nearly 38 hours after death. There was much hypostatic congestion, giving a very deep slaty-blue color in the dependent parts, particularly the ears and back of the neck. No overt putrefactive changes were observed, the odor being much less than ordinarily noticeable, and in no respect peculiar. The body was fairly nourished and bore, externally, no evidence of disease, save an almost inappreciable thickening from inflammation of the skin of the face just underneath the eyes.

There was a little fluid in the left pleural cavity, which showed some adhesions posteriorly; the right one was nearly obliterated by very firm adhesions of no great intrinsic thickness. The left lung showed a little vicarious emphysema about the fissure and its lower and anterior borders.

The heart and pericardium presented no abnormalities; but a paleness in color of the substance of the former with some friability was determined upon at the very close inspection demanded by the condition of the intima of the arch of the aorta. This showed three whitish, irregularly oval-shaped patches, with raised, cord-like edges. There was no actual destruction of tissue; but appearances suggested beginning atheroma. They varied from 15 to 20 millimeters in length, their breadth being one-half their length, and their long axes were in the direction of the vessel. Near the origin of the left subclavian and carotid arteries there were several deeply reddened patches of somewhat larger size, two of which were covered with clot, which I thoughtlessly detached under the water tap. The blood in the large venous trunks was fluid and very dark in color.

The left cusp of the pulmonary valve at its anterior extremity showed a small papilliform enlargement that seemed of hemorrhagic origin. The larger cusp of the mitral valve was covered in its center for half its area by a whitish patch, which seemed to increase the opacity of the tissues without adding to their thickness. There were no evidences of endocarditis found after very careful search; certainly neither ulcerations nor vegetations.

The pathological appearances resolved themselves under the microscope into a somewhat intense capillary injection with very little inflammatory exudation, either corpuscular or fibrinous, even in places where the processes were most intense. The outlines of the elements were much obscured in what appeared like a mucoid degeneration. The bacilli hereinafter described were present in such numbers as to stain with Delafield's hematoxylin.

The stomach contained about a pint of fluid well mixed with partly digested food; it, with the rest of the intestinal tract and the other organs of digestion, appeared healthy in every respect. The liver was normal to naked eye appearances, except for an alteration in its color (more noticeable after hardening in alcohol) best described as leaden. The spleen was adherent to the anterior wall of the abdomen, and it ruptured under the force necessary to separate it. It appeared intensely injected.

The kidneys were normal in size and in all appearances, save for the high contrast afforded the too light colored pyramids by the cortical substance. That this was too great was not admitted by all four of the medical men present at the time they were examined. There was no adhesion of the capsule of either. At the upper posterior part of the right one a small retention cyst was found. It was spheroidal, about 15 millimeters in diameter, and contained only sanious fluid. Some rather large vessels crossed over its inner wall. That part of the cortex limiting it posteriorly contained several small hemorrhages, and mounted sections of it show many small perforations, some of which have resulted upon the destruction of glomeruli and of structures contiguous to them.

So few microscopical evidences of disease were present in this kidney that it was doubted whether it would show much structural alteration by two observers, who had been asked, each independently of the other, to examine it, after it had been preserved in alcohol for some time. Unfortunately the urine in the bladder was not collected either for the estimation of its quantity, to determine in some measure the rate of excretion by these organs immediately prior to death, or for examination.

Microscopically the kidneys show a very intense nephritis, even the glomeruli participating, as their enormously proliferated nuclei show. There is some thickening of the smaller vessels, but few evidences of the existence of chronic endarteritis. Hemorrhages are rather numerous in the vicinity of the cyst mentioned. There is much degenerative change in the tubular epithelium. A few of the tubules contain hyaline casts, and some collecting tubes casts that seem made up of nuclei very little changed. No coagulation necrosis was found, and no albumin could be demonstrated in the capsule of Bowman in those sections in which a solution of it had not been used in the process of mounting the tissue (Mayer's method).

The brain was not examined. Every portion of the tissues examined, the kidney, liver, spleen, myocardium (left ventricular wall and the largest columna carnea of that ventricle), the mitral valve, the wall of the aorta, and the pulmonary artery and one cusp of its valve, was found to contain swarms of a bacillus that decolorized by Gram's method, but which stained readily with the usual aniline colors and even with hematoxylin, as has been stated. The margins of some sections of kidney and liver and the adventitia of the large vessels, contain a bacillus that stains after Gram; it may be a *post-mortem* invader—possibly it is an associated infecting agent.

The size of the former bacillus (1 to 1.1 micromillimeters broad, and 3 to 6 micromillimeters long), its tendency to occur in chains of from 3 to 6 end to end, and its staining reaction, suggest forcibly the bacillus of malignant edema, whose pathogenetic attributes vary between somewhat widely separated limits. Welch has shown the accountability of another microörganism for much mischief formerly ascribed to the bacillus under consideration, and, as I remember, in the only case directly attributed to the latter in American literature (Hoegh's case: *Medical News*, v. 57, p. 310), the presence of the organism in the tissues was not ascertained.

The following clinical history affords little information as to the nature of this infection, or the source whence it arose:

X——, sailmaker, American, aged 60½ years, a most methodical man, of correct habits and well ordered life. His dwelling in Vallejo, Cal., where he spent his time when off duty, was regarded by his medical attendant as insalubrious from general considerations merely. I have been told by a former physician of his that he had been much troubled by facial erysipelas of late years; but none of these attacks seem to have incapacitated him from carrying on his comparatively light duties as officer of the deck aboard a receiving-ship. For two months before his death he had considered himself out of health and had lost ten pounds in weight.

On March 8th, both cheeks below the eyes were swollen only a very little, being reddened and slightly brawny. The heart was acting feebly; pulse at the wrist, 36 per minute. Urine scanty, showing no albumin by heat nor by Heller's nitric acid test, Tonics and cardiac stimulants, with an ichthyol ointment locally, were prescribed. He strongly demurred to going on the sick-list, and at length was ordered to go to his home by Surgeon Ross, who impressed upon him the necessity of good care, nourishing food, and rest. He was seen there on the next day by the doctor. His heart was acting feebly and badly, and he is noted as appearing bloodless. Further attempts at cardiac stimulation were made throughout the day. About 8:30 P. M., after a fairly hearty supper, he complained of some indefinite uneasiness, and, in the absence of his companion, who had gone for assistance, he fell from the sofa lounge, where he had been lying partly dressed, to the floor, on which he was found lifeless.

No one can regret more deeply than I the incompleteness of the work on this case, for which I had no opportunity to prepare in any way. When I found the Gram-decolorizing bacillus, I inoculated a rabbit with a bit of tissue out of 80 per cent. alcohol, in the hope that some spores might survive; and I still have the animal under observation, showing a fibrous nodule under his skin that encloses the fragment of aorta. I am sensible of many grave sins against science in detailing at such length a case open to the inclusion of so many fallacies; but I shall plead in extenuation the importance of the serious kidney lesion, which was entirely without symptoms in the life of the patient, and the presence of a bacillus that may not have been an agent of decomposition.

This indiscretion recalls the experience of an enthusiastic bacteriologist, who had found what appeared to him like anthrax bacilli in the kidney of a woman dead of puerperal septicemia. After many triumphant demonstrations, he showed it to a very eminent pathologist, who said, impressively: "Young man, you can't fool me. That's a piece of rotten kidney." My sections may show only a little of that same; if so, things seem to me to have rotted very interestingly.

The second case is that of a Chinese servant, who presented slight thickening and swelling of the right cheek. I have seen a good deal of erysipelas in mulattoes and in the Alaska Indians, who are in many particulars much like Mongolians; and I doubted at the outset if this were an attack of that disease. He had a temperature of 102° F. for the first day only; afterward it did not exceed 99° F. Small vesicles, closely resembling those of zoster, appeared on the second day; but I was unable to satisfy myself as to the presence of micro-organisms in the serum from them, being unable to exclude extraneous matter, and to make cultivation experiments. There was slight malaise and some pain in the limbs, but no nausea. The urine was normal in all respects. A medium-sized rabbit was inoculated with serum from a vesicle and with blood and serum from the actively inflamed border of the patch of affected surface, in the peritoneal cavity, in the vein of the ear, and in the subcutaneous connective tissue. No appreciable disturbance of its health resulted.

On the third day there was noticeable abatement of the inflammation under the use of a moist dressing; on the fourth the trouble had extended posteriorly, involving the right ear and the skin over the mastoid process, extending as high as the temporal ridge. It appeared to be much less violent in character, and no other vesicles formed. This is noted to exclude drug eruptions, as the treatment was not changed from the beginning; some vesicles, moreover, were seen where the disinfectant was not applied, *e. g.*, over the right nasal bone. There was only very slight tenderness, no spontaneous pain, and hardly any lymphatic involvement.

A second inoculation of the rabbit was made as thoroughly as possible on the fourth day, but without positive result of any kind. At this stage of the case the patient refused to take any more tincture of iron, although he yielded to my professional solicitations to the extent of continuing the local application. As he was obviously convalescing, I consented to his consulting his Chinese physician, and I helped him to get leave of absence for that purpose.

He returned, well, at the expiration of his leave, and he amazed me almost beyond expression with his pidgin English account of the consultation. His respected adviser, he gave me to understand, like myself, was not quite clear in his own mind as to the exact nature of the disorder; he considered that it was unnecessary for him to prescribe, as he was convalescent, and no honorarium was desired. He was well-disposed enough to add that the man-of-war's doctor had done very well for him, difference of race considered. I disclaim the personal compliment implied in choosing to ascribe the impressive nature of the medical services rendered to the presence of the rabbit in the case. Great is bacteriology, even in its failures!

U. S. Coast Defense Vessel Monterey, Mare Island, Cal.

CASES OF SKIN GRAFTING ACCORDING TO THIERSCH'S METHOD.

By THEO. RETHERS, M.D., Assistant Surgeon to the German Hospital, San Francisco.

Read before the California Academy of Medicine.

You are all acquainted with Thiersch's method of skin grafting, which needs no further elucidation or praise on my part. You have heard the subject discussed at former meetings, so that I need not go into details concerning the history of the method, the reasons why it has supplanted former methods, nor give an elaborate description of the operation itself, except that I shall explain small deviations pursued in the cases below, as they are at variance with the methods expounded to this society at former meetings.

I would have hesitated about reporting so few cases, were it not that there are among them two identical with a case reported at your last meeting as "Idiopathic Gangrene of the Scrotum," where, it seems, castration, followed by suture of the skin, had been suggested to rectify the defect. This would have been a serious surgical error, and it can be of no harm when direct attention is called to the treatment of such cases.

The preliminary preparation for a skin-grafting operation consists in the disinfection of the region, usually the thigh, from which the graft is to be taken; shaving of the skin is necessary, in order to procure a perfect aseptic graft. If we are about to graft on an old chronic ulcer of the lower extremities, then it is absolutely sufficient, after having disinfected the immediate neighborhood to scrape off the granulations with a blunt curette; the removal of the granulations leaves a fresh, bleeding, and aseptic surface, so that preliminary preparations for the disinfection of the ulcer during the days immediately preceding the operation, become entirely superfluous. If it is necessary to remove the indurated edges with a knife, although a curette will do this work, as a rule, just as well and with much less bleeding, the Esmarch ligature may be applied.

If the ligature is used we should not apply our graft to the surface which is to be grafted until we have controlled all hemorrhage, especially of small spouting arteries. In order to accomplish this result, the wound should be covered with lint gauze, which should be pressed to the prepared surface, most conveniently by pressure with the hands. Then the Esmarch ligature is loosened, and after a short time the wound is relieved of the compression by the removal of the gauze. Usually the bleeding has now stopped, except that from small arteries, the latter being caught with hemostatic forceps and twisted; should this not suffice, catgut ligatures may be applied.

If this procedure is not followed out, we may have a small hemorrhage beneath the skin grafts after removal of the Esmarch, followed by suppuration and necrosis of the skin grafts. The ligature may now, as a rule, be laid aside, except in cases where the patient is very restless during the anesthesia, or vomiting. Under any of these circumstances bleeding invariably takes place, either directly from the blood vessels, or as a transudation from the surface of the wound, thus jeopardizing the existence of the graft. In such cases it is advisable to replace the Esmarch ligature and keep it in position until the grafts have been applied and the extremity bandaged somewhat tightly, in order to exert compression upon the grafts and the surface with which they come in contact.

Where old cicatrices are to be removed and replaced by skin grafts the hemorrhage is often very profuse and many ligatures are necessary. Here it is advisable, after having removed the cicatrix and ligated the vessels, to let the surface granulate, and several days afterwards to cover the surface with skin grafts. We are then sure that the ligatures will cause no disturbance and that the muscular or subcutaneous tissues have become covered with healthy, fresh, and flat granulations. If the wound has in the meantime been treated aseptically or antiseptically, the grafts may be applied directly to the granulations, to which they will adhere, or we may first scarify the surface and then apply the grafts, having stopped the bleeding by pressure upon the surface with lint gauze.

Both surfaces having been prepared, the skin is removed by means of a razor. Several methods have been proposed to prevent the slipping of the skin of the thigh from under the hands of the assistant, whose duty it is to keep it stretched while the grafts are being removed. Dr. Dunham, in the *Post-Graduate*, has suggested the wearing of rough gloves which had been sterilized beforehand, and Dr. Mixter has constructed special instruments for this purpose. These consist of a fenestrated curved plate, having its under surface lined with sharp needle-points to keep the plate in place on the thigh to which it had been adapted. A roller is used for the purpose of pressing the skin between the edges of the opening in the plate. There is also a knife resembling an amputating knife and with a specially constructed handle.

Should the skin not be stretched sufficiently between the hands of the assistant to prevent it from following the side movements of the razor, I use the ulnar side of my left hand between the razor and the assistant's hand below, merely pressing the skin horizontally and at the same time distally. The razor is kept moist by dropping on it a 1-per-cent. salt solution, which prevents the graft from being torn.

I prefer to apply the grafts immediately to the wound, rolling them off the razor and spreading them out by means of blunt sounds, the grafts overlapping the edges of the wound, and of one another. Care should be taken that air be entirely excluded from between the grafts and the wound, since it often happens that on some spot the air is retained as a large bubble, caused by the skin being rolled off the razor unevenly. This retention also takes place when the granulations are not flat, but uneven, and prevents the direct contact between the graft and the wound. This portion of the graft generally becomes necrotic. The air is removed by gently pressing upon the graft with a sound toward the periphery.

When this has been accomplished, the graft is dusted with iodoform, gauze applied, and the Esmarch, if still in position, removed. Dr. McBurney first suggested that the Esmarch ligature be retained, exerting light pressure, for 1½ hours after the operation. This is entirely unnecessary, for the compression exerted by the dressing and bandages is fully sufficient to prevent any bleeding, and to keep both graft and wound surface in direct contact, adhesion between the two taking place similarly to that of any wound healing by first intention. Besides, it should not be forgotten that all hemorrhage has been controlled before the graft was applied.

As in the dressing of most wounds, here also the dry dressing with aseptic material is preferable. Some surgeons are accustomed to dress with wet lint gauze, moistened in a salt solution, and to drop a fresh solution upon the dressings of the wound every few hours, following the transplantation. This is absolutely unnecessary and superfluous, for the life of the grafts depends upon their contact with the surface of the wound, and upon the plastic and serous exudation between them.

If anything happens to prevent these conditions, the grafts are doomed and the salt solution can be of no use toward accomplishing such adhesions. For this reason I do not see why the grafts should be protected from pressure by specially devised contrivances, as has been lately suggested with a claim of originality; in some cases it is even contraindicated. The operation is of itself extremely simple, requiring only a knack; the simpler the incidentals of the method, the better the chances for its success.

If it be desired to cover the grafts with a moist dressing, it is advisable to moisten the dressings with a 4 per cent. boracic acid solution, as has been suggested, which does not become foul after a space of 3 to 4 days, as the salt solution usually does.

This dry dressing need not be removed for 6 or 7 days, unless the wound was in especially vascular tissues or the hemorrhage not easily controlled. In such cases it is better to remove the dressings after the second or third day; and wherever a slight hemorrhage has taken place under the graft, as indicated by dark-blue streaks and, perhaps, by the raising of the skin, an incision with the scissors should be made, to prevent the suppuration which will ensue from destroying the whole graft.

The skin of the thigh heals most quickly under the application of the oxide of zinc salve. I have seen a great many cases treated in this way, and without any failures where these methods have been adhered to. The following cases are reported in illustration:

J. K——, 45 years of age, saloon keeper; corpulent, weighing about 250 pounds, of nervous temperament, had been suffering from a stricture of the posterior part of the urethra, for several months before entering the hospital. Twelve days before his admission, August 11, 1893, the scrotum began to rapidly grow larger, with great pain and fever. Three days afterward discoloration and gangrene set in, patient lost appetite, and grew weak. The temperature was 102° F. The entire front half of the scrotum sloughed off, leaving the testicles denuded, the edges of the skin remaining, ragged, discolored, foul-smelling; the testicles covered with foul-smelling purulent matter. The whole was well disinfected, edges trimmed off with scissors and covered with a moist antiseptic dressing. Internal urethrotomy was performed. The wound was dressed daily. In a short time a line of demarcation formed, and healthy red granulations appeared. After 4 weeks the wound, as well as the denuded testicles, were entirely covered with fresh, healthy granulations. Transplantation of skin from thigh in the manner just described was carried out, and there was no disturbance in the healing process. Patient was discharged shortly afterward as cured.

M. A——, 25 years, had been troubled on passing his water for some time; stream diminished and spiral shaped. Three days before entering the hospital he experienced a sudden pain in the region of the bladder, and found himself unable to urinate as freely as formerly. The scrotum began to swell, became reddened and painful. There was fever and several chills. On examination, patient was found to be weak and anemic; pulse, 80 to 90; temperature, 105° F.; scrotum red and swollen, several spots already gangrenous; poster stricture of urethra. Gangrenous parts of scrotum removed, the whole disinfected and covered with moist antiseptic dressings. Internal urethrotomy. The following days the temperature ranged between 101° and 102°. A line of demarcation formed; the testicles, now entirely denuded of skin covering anteriorly, and covered with ill-smelling, foul pus. Ten days after entrance severe pains were felt in the region of the right inguinal canal, the parts being swollen and painful to the touch. An abscess formed in the canal, which was opened and drained. After 4 days the temperature fell to about the normal. Under stimulants, iron and quinine, improvement of the general condition of the patient followed, with strong reaction in the wound. After two weeks the drainage tube was removed from the inguinal canal. Two weeks later the abscess healed, and the testicles were covered with healthy red granulations. The granulations were scarified and skin grafts from the thigh applied, after stopping the bleeding resulting from scarification by pressure with gauze. There was no disturbance in the course of healing. Patient was discharged, cured, 8 weeks after entering the hospital, and 2 weeks after skin grafting.

These are the two interesting cases to which I wished to call attention, and which prompted the writing of this paper. It was only necessary to wait until strong reaction had set in and until the wounds were covered with healthy granulations; the defect was then easily removed. The scarification of the granulations in the second case could have been dispensed with.

I have also had several cases of chronic varicose ulcer of the leg, treated in the same manner. This seems to be the quickest, best and most rational way of treating the ulcers. Very frequently, on removing the dressings on the second or third day after the operation, one is surprised to see that the wound appears to be entirely devoid of the grafts which have been applied. This is not the case, however. It is only the outer or upper layers of the epidermis which have sloughed off. After 4 or 5 days these have been reconstructed, and in place of the former ulcer we have a soft, pliable skin of reddish tint.

Syphilitic ulcers may also be treated in this way. I have operated on one case where there were two ulcers on each leg, over the tibiæ. The results are better than antisyphilitic treatment alone could achieve, for the healing process is quicker and leaves no scar.

Two cases were for keloid of old scars, one of an old scar on the cheek of a boy 15 years of age, the other on the backs of the hands of a girl 18 years of age. The scars and keloid were removed, together with considerable healthy skin from the neighborhood, and the surface grafted. In the case of the boy the results were only partially successful, for some time afterward small keloid formations appeared on the edges of the graft. The case of the girl gave us considerable trouble. The backs of both hands were covered with scars and keloid from burns received at a gas explosion. The scars extended downward to a considerable depth, and in some places were slightly adherent to the subcutaneous tissues. The bleeding was considerable, and during anesthesia the patient coughed continually. The Esmarch was used, the bleeding stopped for a greater part through pressure with gauze; but it was necessary to ligate a few spouting arteries, which gave considerable trouble afterward by the ligatures sloughing out, and also by secondary hemorrhage under the grafts.

This inconvenience could have been avoided had we let the fresh wound granulate first and grafted later. Though the skin grafting had been successful, keloid formations again appeared. even where the edges of the grafts came in contact with one another. A considerable part of the covering of the backs of both hands were again excised and grafted a third and fourth time; but each time keloids formed again, to be sure, finally, only as small red lines on the edges. The patient being more than satisfied with the results, we desisted from making any more attempts. I might add that even on the thighs, from whence the grafts were taken, keloids afterward formed; there being a general constitutional predisposition to keloid formation.

Two cases of laceration of the scalp, with loss of the skin, were also treated in the same manner; in one of the cases a flap 2 inches in length and about 1 inch in width had been taken from the side of the head for the plastic formation of an ear, which had been torn off in a runaway accident. The defect on the scalp was grafted, the grafts adhering readily and easily to the periosteum of the cranium.

Three cases of ulcerated surface of the stump of an amputated femur, in one of which the anterior flap had become gangrenous, were treated in the same manner and with the same successful results.

200 Stockton street.

A DISCUSSION OF THE LINES OF TREATMENT OF PELVIC ABSCESS.

By ALBERT H. TAYLOR, M.D., Assistant Demonstrator of Anatomy, Cooper Medical College, San Francisco.

Read before the San Francisco Medico-Chirurgical Society.

The tendency of writers on pelvic diseases within the last few years seems to be toward generalization, and where, ten years ago, we had several terms to indicate the exact location of an inflammation about the pelvic organs, to-day we have one general term.

Schroeder, in his work on "Diseases of the Female Sexual Organs," published in 1875, speaks of a perimetritis or pelvic-peritonitis, and a parametritis or a connective tissue phlegmon, giving the lines of differential diagnosis. But, as a solace to the less skilful, says it is difficult to make the diagnosis with absolute certainty during life, and even *post-mortem* it may be difficult to discriminate between the two diseases.

It has been proven, clinically and pathologically, that an inflammation rarely if ever confines itself to a particular tissue within the pelvic cavity, although it may occupy a particular locality. Thus, we may have an inflammation of the cellular tissue about the cervix uteri, or in Douglass' pouch, nearly always secondary to a peritonitis, rarely as a direct infection coming from the lymph channels passing through. As peritoneum and connective tissue are so intimately connected, inflammation of one almost invariably involves the other. The same may be said of an inflammation involving the fallopian tube and ovary; hence, the later works on gynecology use the general term pelvic inflammation, as the treatment is common.

As in all inflammations, the termination may be reached by several routes, namely: resolution, organization, which means the establishment of vascular supply to the resulting exudate by which its breaking up is stayed, and suppuration or the formation of an abscess. Nature is always on the alert when this sort of warfare is being waged and soon has the enemy a close prisoner, where he is destroyed at her leisure. As our aim should be to assist nature at all times, and in this, above all times, is the hand of the surgeon needed, as it has been very truly said that a pelvic abscess should never be given an opportunity to open itself.

The question is, how can the pus be thoroughly evacuated and the baneful results of the adhesive peritonitis relieved with the least danger to the sufferer? There are two well traveled roads leading to the pelvic cavity; that by the outlet or vaginal route, and that by the inlet that is above the pelvic brim through the anterior abdominal wall.

On digital examination in a case of pelvic abscess, we frequently find a bulging in the posterior vaginal fornix in the region of the pouch of Douglass, in which fluctuation is discovered. It is immediately suggested to the mind of the surgeon to aspirate, which may or may not be followed by dilating the punctured wound by means of the dilating trocar, putting in a T-shaped, self-retaining drainage tube and washing out the abscess cavity with some antiseptic or packing with iodoform gauze.

The simplicity of this method appears at once, but though simple as to the surgical skill required, it is not without its dangers, even to the most careful operator, and the few statistics gathered from skilled gynecologists in this city show a greater mortality than the seemingly more formidable operation of opening the abdomen.

It is almost impossible to have an aseptic vagina, having, as it has, a foul drain constantly discharging into it through the cervical canal. Thorough antisepsis or asepsis is difficult to carry out. Germs are carried to the now thoroughly aroused peritoneum and serious trouble may ensue.

Should the operation prove a success in regard to the safe evacuation of the pus discovered, are we safe in saying our patient is thoroughly relieved? Laparotomies have shown us that we are not always dealing with a single abscess cavity in the suppuration ending of a pelvic inflammation, but that while there is an abscess in the cellular tissue about the cervix, there may be another in connection with the ovary, and another in or about the tube, these being primarily the cause of the pelvic inflammation. In the adhesions resulting from the plastic exudate, a number of little chambers are formed, each with thickened walls—nature's bulwark against general peritoneal infection—and each containing some of the purulent exudate that goes on poisoning the nerve centers until the life of the patient or that of the poison is destroyed.

Possibly the most disagreeable and invalidating symptoms resultant to a pelvic inflammation are those caused by the many firm adhesions that bind and fix the pelvic viscera. The relief of these we cannot hope for through our vaginal opening.

Again, as the majority of pelvic inflammations are caused by a diseased tube discharging its virus into the peritoneum, and as surgery always aims to remove the cause of the disease as well as the disease itself, so, should this condition be discovered, the offending part can be removed and the patient given a far better chance for a permanent recovery. As it is our imperative duty to do the most good with the minimum of danger, the road through the abdominal wall seems to offer the most advantages.

The *technique* in opening the abdomen for an abscess in the tube or ovary is the same as that for removal of the uterine appendages for other causes, and will not be given here, as I only aim to discuss the different lines of treatment to be employed to obtain permanent relief from an abscess cavity within the pelvis.

If, on opening the abdomen, the abscess be found to be extraperitoneal, and not too deeply situated, the sac may be aspirated and thoroughly irrigated, the opening stitched to the abdominal incision and packed with iodoform gauze or drained by the insertion of a drainage tube.

Should it be found difficult to bring the sac high enough to be drained through the abdominal opening, the vaginal opening can be made and drainage established from below. In case of rupture of any of the abscesses located about the tube and ovary, a thorough flushing of the pelvic cavity with large quantities of hot water, either plain or mildly antiseptic, will usually remove all sources of peritoneal infection.

No surgical operation that gives a chance for the entrance of poisonous germs to the tissues should be performed without a strict attention to cleanliness, and in no case is this injunction so imperative as when the delicate lining of the abdominal cavity is to be molested. I once heard a prominent surgeon, when asked what had been his chief gain from a recent visit to the European hospitals, answer, simply to be more cleanly. As he had seemed to take all the precautions possible before, this added care hardly seemed necessary. Yet, it is this extra attention to this most important detail that is the main secret of success in abdominal surgery.

In summing up the plans of treatment of pelvic abscess, like many other surgical or medical problems, no rigid rules can be given, and much must be left to the judgment of the surgeon or physician.

Should there be simply a connective tissue phlegmon, either extra or intra-peritoneal, opening through the vagina would be the simplest method of relief, requiring less surgical skill and *technique*.

The same plan may be followed in a general pelvic abscess, when it can be demonstrated to be independent of any tubal or ovarian connection; a very rare condition, however. Then aspiration through the vaginal wall may be made to give temporary relief until arrangements can be made for the more complicated operation of celiotomy.

As the cause of the trouble can most often be found in the fallopian tube, the indication for the superior opening is clear in the greatest number of cases; the mortality being about 10 per cent. among the many operators, but being very much less—practically nothing—among a few careful specialists.

423 Ellis street.

GASTRIC ULCER.

By W. E. Bates, M.D., Davisville, Cal.

Read before the California Northern District Medical Society.

I have limited the scope of my paper to a rough outline of the etiology and pathology of this malady, and confined myself principally to the detailing of some cases that have come under my immediate care.

The primary cause of ulcer of the stomach may be one or several of the following conditions: Traumatic or thermic irritations; violent emesis; hemorrhages due to congested conditions; hyperemia and stasis in circumscribed vascular areas of the mucous membrane; hemorrhagic infarctions; spasm of the vessels and atheromatous, amyloid, or aneurismal degeneration. The pathology can be summed up in a word—necrosis. Necrosis of one or all the coats of the stomach, due to one or several of the above-named conditions. Repair begins only when the anomaly producing the ulcer is removed. Then reactive inflammation of the base of the ulcer and surrounding tissues sets in and subsequent cicatrization becomes possible. With these few remarks, I will pass on to the history of a few cases:

CASE I.—I was called in the forenoon of May 25, 1890, to see Charles G——, a farmer, residing 4 miles south of Davisville. He was a fairly well built man, 5 feet 6 inches in hight, and weighing 138 pounds. Six years previous he was thrown on the pit of his stomach, across the horn of a saddle by a bucking horse, after which he vomited considerable blood. He was more or less sore therefrom, but seemed to recover in a few weeks from all effects of the fall. Some time after, dyspeptic symptoms supervened, and he was treated off and on for these with no permanent benefit. During the past three months the symptoms had gradually increased in severity, and for some weeks his suffering had been very great. For a week he had been vomiting, and often, while out plowing, he would vomit a pint or more of blood. The past two nights he had awakened and vomited nearly a half chamberful of blood each time. This morning, however, he had lost so much blood he was unable to leave his bed. There was nearly a half chamberful of clotted blood by his bedside, and he was exsanguinated to an alarming extent. There was tenderness on pressure over the pit of the stomach extending slightly to the right. He complained of almost constant pain, but it was greatest a half hour after eating.

I enjoined rest, both locally to the stomach and generally. An enema of fluid extract of ergot was given, as I had none that could be used hypodermically, and *per os*, 20 grains of bismuth subnitrate was administered every three hours. At the end of eight hours, as this did not arrest the hemorrhage, I endeavored to check it by 3-grain pills of gallic acid, but the oozing still continued, and the patient died from loss of blood on the third day.

At the autopsy I found an ulcer on the posterior wall of the stomach, near the pylorus, the size of a 25-cent piece. The base of the ulcer was the pancreas, it having eaten through the stomach after having formed adhesions to that organ. Quite a large vein was partially severed, and through this the blood had poured. This specimen I now submit for your examination.

CASE II, is a younger brother of the patient just referred to. He is 34 years of age, and has complained of dyspeptic symptoms for several years past. I first saw him at my office in March, 1891. The dyspeptic symptoms dated from a blow on the abdomen from the tiller of a header.

He was suffering considerable pain from his ride of 7 miles into town, and his wife, who accompanied him, said he was unable to do any work that was heavy, as any straining on his part increased the pain. This pain he described as circumscribed, of a burning, gnawing character, and increased on eating. He had a constant, craving appetite and thirst. There was tenderness on pressure just below the costal cartilages of the seventh and eighth ribs on the left side. The tongue looked glazed, cracked and irritable. There was no nausea and no fever.

His passages were flat and ribbon-like in shape, about ¾ of an inch broad, and ¼ of an inch in thickness. His tendency in walking was to stoop forward and retract the abdomen. There was an increased amount of hydrochloric acid present. My diagnosis was an ulcer of the stomach, with adhesions to the transverse colon, causing stricture of the latter organ.

I first enjoined moderate rest (that is, to desist from work), and placed him on large doses of bismuth subnitrate in elixir of lactopeptin, and gave McMunn's elixir of opium to ease pain. As this did not improve his condition, he was ordered to bed, and to be fed *per rectum*. A large fly blister was placed over the seat of pain, and when healed, massage was instituted. His rectal injections consisted of peptonized milk, raw eggs, beef tea, etc.

For fifteen days he was nourished exclusively in this way, during the latter end of which time he could think of nothing, talk of nothing, and dream of nothing but something good to eat. In his dreams he would see vast tables spread with all the good things he had ever seen or heard of, and on which he would gourmandize but never be satisfied. He held his flesh fairly well under exclusive rectal alimentation, but at the end of fifteen days his pains having left entirely, except some tenderness on pressure, he was placed upon crackers and milk in small quantities, and an occasional meal with what he called his false teeth—the syringe. The milk at first was peptonized with Fairchild's tubes, but it was found that it caused less uneasiness when not peptonized.

In about five weeks the tenderness over the stomach had entirely disappeared, and I began to dilate the stricture by introducing Wales' soft rubber rectal bougies. The first one it was possible to introduce being No. 3. The sizes were very gradually increased until it was possible to introduce a No. 12, the largest size. As the bougie passed the stricture he felt pain in the same spot where he used to feel it when he first called on me. I therefore was quite positive that the trouble was originally an ulcer in the stomach, with subsequent adhesions to the colon, causing a stricture in the latter.

Patient's diet was gradually extended until he could eat everything within reason, and to-day he is strong and well.

CASE III was that of a man 48 years of age, who was for years a bartender. He came to my office in October, 1891, complaining of pain in the pit of his stomach, and, what alarmed him most, a slight jaundice. He had had pain in his stomach, and also vomiting for several years, but his pains had increased lately, and the jaundice had just been noticed, I found tenderness on pressure over the pit of the stomach, extending to the right under the edge of the costal cartilages. About half an hour after taking food the pain and distress were markedly increased. Emaciation was extreme.

I ordered him to bed, put a 4x4 cantharidal plaster over the seat of pain, fed him *per rectum* entirely for eight days, and used inunctions of pure codliver oil freely. After the blister had healed, gentle massage was instituted. This procedure I carry out myself, as a rule, with a two-fold object: in the first place, with the idea of aiding nutrition and absorption of the adhesions; and secondly, to elongate, if possible, the bands of adhesions which may still remain, thus freeing the organ and admitting of its better mechanical working. In eight days his pains had ceased and food was gradually given *per os*, consisting mainly of well-boiled rice and cream, as this seemed to best agree with him. The jaundice gradually disappeared, and was entirely gone in a fortnight. Within a few months the patient had improved greatly, but he has never grown very stout. His stomach is still weak, as he has a catarrhal gastritis, a result of his long years of drinking, and will not submit to lavage of the stomach and a course of treatment. While not entirely cured, he is up and about, able to attend to his business, and with some regard to his diet enjoys very good health.

As the patient had ceased drinking for several years, and there was no decrease in the size of the liver, I believe in this case I had an ulcer of the stomach, with adhesions to the liver.

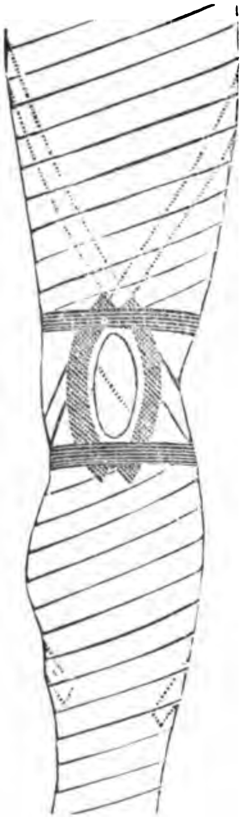
A NEW METHOD OF TREATING FRACTURED PATELLA.

By Donald McC. Gedge, M.D., San Francisco, Cal.

A year ago a patient came under my observation, suffering from a fracture of the right patella. She was 27 years of age, and in fair physical condition, although at the time in an inebriated state, and threatened with *mania a potu*. She was unable to give a lucid account of herself, but sufficient information was obtained to conclude that the injury was due to direct violence, owing to a severe fall. She was suffering from intense and almost uncontrollable nausea and vomiting, and very considerable pain.

Examination of the injured limb revealed a very swollen and ecchymosed condition of the right knee, all landmarks being nearly obliterated, and the patella resting above and surrounded by considerable effusion. Over its center an abrasion about ½ inch in diameter presented, from which radiated an oblique line of indentation, from above and without, downward and inward. The limb was slightly flexed and painful upon manipulation. Palpation gave evidence of an oblique fracture of the patella with about ¾ of an inch separation.

The limb was placed at absolute rest and applications of lead and opium made for 24 hours, the compresses being covered by cloths wrung out in ice water. Upon the reduction of the active conditions present, a means of dressing was sought that might insure the best results exclusive of radical measures. Circumstances demanded the employment of what was at hand, and the usual conservative methods having been generally condemned, I devised and successfully carried out the following method:



A strip of moleskin plaster 1½ inches wide was taken, and the upper end applied firmly to the upper and inner surface of the thigh. It was then brought downward, forward, and outward, with considerable tension, crossing at the upper margin of the upper fragment of the patella, which, by hyperextension of the limb and manipulation was brought down to its normal site, thence outward and downward on the external surface of the joint, down upon the calf of the leg, then carried behind and fastened on the inner surface of the leg well down. A similar process was gone through by beginning on the outer surface of the thigh, and proceeding in an opposite direction. These two strips, crossing as they did at the upper fragment, allowed of very considerable tension and fixation. Two strips, 3½ inches wide, were now rolled with the gummed side out, shaped and fitted snugly into the sulci on either side of the patella. Two other strips, 1½ inches wide, were next taken, and passed around the limb above and below the site of injury, drawn firmly, and made to include the ends of the pads in the sulci, and to hold them firmly in position. A posterior splint of pasteboard, extending from the middle of the thigh to the lower third of the leg, was next fitted. A long roller bandage was applied so as to include the entire limb from the toes up, skipping the site of injury.

The advantages gained were total fixation and retention of the fractured portions in apposition, the site of fracture being left open to view, and admitting of any local application indicated, and complete observation of the progress of repair. The dressing was readjusted in 10 days, and slight passive motion begun at the end of two and a half weeks. At the end of five weeks complete union was obtained and the patient left for home, and has not suffered any since. Walking is entirely normal. This is the only case I have had in which to try this dressing, but I think it will recommend itself for simplicity, and that it will be found valuable in similar cases where reduction is possible.

406 Sutter street.

THE USE OF CHLOROFORM IN ANESTHESIA.

By H. W. STRADER, M.D.

Read before the Sacramento Society for Medical Improvement.

My reason for presenting this time-worn subject for your consideration is the fact that a majority of surgeons in the United States are not using chloroform for anesthetic purposes. I propose to show that this is not in accordance with the opinions of medical men who have made a study of the subject, and whose opinions are entitled to consideration, owing to their large experience. I shall quote largely from recent writers on this subject, especially from a work by Dr. Hewitt, of London, published in 1893, and from lectures delivered last year by Dr. William Henry Porter, of the New York Post-Graduate School.

Agnew's Surgery, Vol. 1, page 291, condemns the use of chloroform for general anesthetic purposes in no unmistakable terms, and says "it should be excluded, with few exceptions, from general anesthetic purposes." Other writers, especially from 1880 to 1885, follow the same course. So far as I have been able to determine, more recent writers wish to concede to chloroform certain conditions in which it is more suitable than ether. These conditions I propose to review in this paper.

Chloroform should correspond to the following tests: It should have a specific gravity of 1.491 and a boiling point of 60.16° C. It should be perfectly transparent and colorless. It should be absolutely neutral to test paper. It should possess an agreeable, bland, and non-irritating odor. When a portion is allowed to evaporate spontaneously from a watch-glass it should leave no residue, either of water or any substance possessing a strong smell. When shaken with concentrated sulphuric acid no brownish coloration, or only the faintest, should result. It should form no precipitate with a solution of silver nitrate. It should not acquire a brown color when heated to the boiling point with caustic potash.

It is a fact that less than 25 per cent. of the fatalities reported are in females, while the administrations proportionately are almost double that number. Why this is so I shall not attempt to answer. Hewitt says: "The age of the patient has of itself no special influence in modifying the effects produced by anesthetics." Infants a few hours old, as well as centenarians, have been safely anesthetized.

"Chloroform does not irritate the air passages as does ether, and is usually to be preferred in children, but chloroform is not absolutely harmless in children, as supposed by some. The principal danger is that too much be given, producing a deep, tranquil sleep, thereby masking any unfavorable symptoms."

The A. C. E. mixture referred to in this paper is composed of alcohol 1 part, chloroform 2 parts, ether 3 parts. This mixture, condemned by some writers, is highly recommended by Hewitt, when properly administered. The A. C. E. mixture is often best with children, and can be followed by ether or chloroform.

"Ether may be given in the aged, if there are evidences of senile changes, but the use of nitrous oxide is especially indicated in such conditions. Excitable, highly-strung, neurotic persons can be anesthetized by commencing with nitrous oxide, followed by ether. High livers, morphine habitues, alcoholics, excessive users of tobacco, etc., usually require a large amount of the anesthetic, and it is among these classes that the death rate is high. It is a remarkable fact that a patient whose health has become somewhat impaired by disease is a better subject for anesthesia than the patient of healthy appearance and general good physique." "This is especially true as to chloroform. The healthy, vigorous and stalwart are by no means the best subjects for anesthesia. It is true their circulation and respiration will hold out longer under any strain, but they do not pass under the anesthetic as do the more feeble. Emaciated children require a remarkably small quantity of an anesthetic. The obese are usually intolerant of any anesthetic, but should any be given the A. C. E. mixture is best, ether in preference to chloroform. Patients of a florid color, distinctly plethoric, short-necked, may, under nitrous oxide or ether, assume a duskiness of features alarming, but it is not of itself an indication of any untoward condition. Anemic patients take anesthetics well, small quantities being required and a speedy return to consciousness follows.

Fixity of the lower jaw, especially when the upper and lower teeth fit accurately, has a tendency to cause difficulty of breathing more than in those whose teeth are defective. If the nasal airway be free, breathing will usually take place through it during anesthesia; but if obstructed more or less, use some mouth prop. Partial nasal obstructions will have a tendency to become complete. Even though the nasal passage be free, some patients do not breathe freely when deeply anesthetized. Morbid growths of the tongue, soft palate, tonsils, pharynx, epiglottis and adjacent parts, from alteration of position or vascular turgescence, interfere with respiration during anesthesia. Glandular, lipomatous and other tumors of the neck, including thyroid growths, seriously lessen the capacity of the airway. The advisability of a previous tracheotomy should be discussed. For these cases great care should be used in the selection of the anesthetic; usually the A. C. E. mixture is the best.

Ether is not contraindicated in all cases of bronchial, pulmonary and pleural diseases, but if given at all it should be very cautiously. The A. C. E. mixture and chloroform should be given in preference to ether in these conditions. In patients who have recently suffered from pleurisy or pleuro-pneumonia, death often results from heart failure, after a struggle. In valvular and other cardiac diseases, the anesthetic must be selected to suit each individual case, and must be administered in such a way that no undue strain be placed upon the heart. In advanced cases the A. C. E. mixture is best. In aneurism or extremely atheromatous conditions, the A. C. E. mixture is best, chloroform is preferable to ether. The danger in these cases is cerebral hemorrhage.

In railway injuries, strangulated hernia, gastrotomy, and other conditions where the patient is in a state of collapse, ether given in the open inhaler is usually best. Nitrous oxide should not be used in these cases. Should the eyelids lose their tone and not close, it is an indication of great prostration of the vital powers, but it may arise from too much ether, or other causes. Caution must be used in cases of "hectic," as well as in those stimulated by alcohol.

Syncope of the worst type has been known to arise during anesthesia in intestinal obstruction. The A. C. E. mixture or chloroform is recommended in peritonitis, perityphlitis and allied diseases and operations. If a patient is sleepy, drowsy and half unconscious, do not use nitrous oxide. The A. C. E. mixture is best. Epileptics can be safely anesthetized.

In advanced diseases of the kidneys, chloroform is the best anesthetic, but ether can, if properly administered, be given, even if Bright's disease be present. Do not operate during menstruation, unless the case be one of emergency. Hemorrhage is more troublesome. An anesthetic can be safely given up to the sixth month of pregnancy, if properly administered. The A. C. E. mixture is best. Do not use nitrous oxide after the sixth month.

For administering an anesthetic the best position is with the body supine and the head and shoulders slightly raised. "Should the operation require the semi-recumbent position, chloroform should not be used or change to ether when this position is assumed. In the latero-prone position ether should be used if not contraindicated.

Operations may continue so long as the pulse can be counted at the wrist. Should the pulse become running, or almost imperceptible, remove the patient to bed at once. We meet with certain cases in which, independently of the anesthetic and independently of the hemorrhage or prolonged surgical interference, symptoms of cardiac depression, possibly of an urgent character, make their appearance." Operations upon the lips, cheeks, jaws, tongue, floor of mouth, palate, tonsils, naso-pharynx and nose, anesthetize with ether thoroughly, and elevate to semi-recumbent position, and endeavor to complete the operation without additional anesthesia. With nasal polypi, laryngotomy, tracheotomy, and other operations upon the larynx and trachea, use chloroform. The A. C. E. mixture is better than ether. In all operations upon the neck use chloroform. It causes less vascular enlargement.

In operations upon the pleura and lungs definite rules cannot be given. The condition of each case must be determined. "In all abdominal operations ether should be excluded, but, if properly administered, it can be given without the usual disagreeable consequences. Ether should never be employed when the abdomen is distended. The A. C. E. mixture is best. Chloroform is best when there is acute intestinal obstruction. In operating upon the genito-urinary organs use the A. C. E. mixture or chloroform. In rectal surgery use ether. Especial care must be employed, as they are often plethoric. Operations upon the brain or its membranes, use chloroform or the A. C. E. mixture."

"Parturition and obstetric operations, use chloroform unless contraindicated by uterine inertia. Ophthalmic operations, use the A. C. E. mixture or nitrous oxide. Manipulations requiring muscular relaxation, use chloroform unless the muscles be flaccid, then use ether. In alcoholic cases, use ether. Etherization followed by chloroform is often necessary in these cases." Chloroform is used in cases of renal and biliary colic, and other acute painful seizures. Chloroform is best in puerperal eclampsia, strychnine poisoning, and tetanus. " In one case of the latter a child was kept under its influence for 13 consecutive days, 100 oz. being used." "The Junker chloroform inhaler has been in use in the London Samaritan Free Hospital for 20 years without an accident."

Dr. Wm. Henry Porter, of New York, says, "Chloroform is just as safe as ether if precautions are taken against its dangers, and death cannot take place from it, if these precautions are observed, but it lacks the primary stimulation obtained from the oxidation of the ether, and its yield of heat and energy in the form of reflex imulation." The same writer says: "Chloroform is less damaging to the chemico-physiological process of the animal economy than is ether, consequently chloroform is safer than ether. More skill, however, is required in its administration. Neither chloroform nor ether can be administered with impunity, as was formerly thought regarding ether."

Dr. O. Kappeler reports 800 chloroformizations, with no fatal results. Of these 420 were males and 380 females, the ages ranging from 14 days to 82 years. Average amount used, 12 c.c.; 33 c.c. used for every minute of the anesthesia. Average time required to produce anesthesia, 8 minutes; 6 gm. to 100 liters of air used in apparatus; 5.5 c.c. were used to make patients ready for operation. Of the 800, 698 did not vomit; 20 showed nausea; 82, or 10 per cent., vomited; 21, or 2.8 per cent., vomited after the operation, 13 cases vomited severely. They had all taken food shortly before. Of the 800, narcosis was good in 667, fair in 81, bad in 62 or 6.5 per cent. The chief cause of unpleasant and disturbing symptoms was potatorium, hysteria, and dread of the operation. Two cases presented dangerous symptoms owing to their debilitated condition. There were 14 narcoses, lasting from 1½ to 2 hours, with no untoward symptoms; 13 of the 800 lasted over 2 hours, with no ill effects from respiration or circulation.

When not contraindicated, I use morphine ¼ gr. and atropine $\frac{1}{100}$ gr. before beginning to anesthetize with chloroform, for the following reasons: Morphine is to some extent a heart tonic; atropine is a respiratory stimulant; the morphine prevents shock; less of the anesthetic is required; the patient rests better after the operation; it prevents too rapid reaction; it prevents vomiting to some extent; the asphyxial symptoms are almost entirely relieved and the breathing is more quiet; morphine before chloroform in cerebral surgery is of especial value in producing anemia of the brain; the stage of excitement is shorter.

The following precautions should be used in administering chloroform; Quiet the fears of the patient; use the recumbent position to equalize the circulation of blood from heart to brain; give, hypodermically, morphine ¼ gr. and atropine $\frac{1}{100}$ gr.; remove all clothing from patient and cover with blankets; do not commence by saturating a handkerchief and covering the face, thus shutting out all air; commence with a small quantity, and if patient coughs violently remove it temporarily, recommencing when the breathing is quiet; do not administer more than is necessary for the operation; a pure chloroform is most essential. Squibbs' is the best that I am familiar with. If after commencing the use of chloroform unfavorable symptoms arise, change the anesthetic; remove artificial teeth; the administrator should not try to watch the operation; do not hurry under any circumstances; do not strangle your patient; do not stick your dirty finger in the patient's eyes; do not keep swabbing the mouth and pharynx with cotton or sponge; do not give a hypodermic injection at every sign of depression.

I prefer to use chloroform, when not contraindicated, for the following reasons; The degree of anesthesia can be better measured than by ether; anesthesia is much sooner accomplished; the patient is not so liable to vomit; it is a better remedy for emergencies, as hysterical spasms; chloroform being a narcotic is a better preventive of shock; chloroform is more convenient and has few contraindications for the general practitioner; the rapidity and ease of use make it of special value on battle fields; it is not injurious to diseased kidneys as is ether; it is more pleasant to inhale; it is not so likely to be followed by pneumonia as ether; it does not produce any increase in temperature; it does not irritate the air passages; it does not require the strength of anesthetics, operator, and assistants to hold the patient upon the table as is sometimes the case in ether anesthesia.

Dr. Hewitt concludes as follows: "Nitrous oxide is the safest anesthetic, the A. C. E. mixture is more safe than ether, and ether more safe than chloroform. He gives the following statistics: Total number of chloroform administrations, 676,767; total deaths, 214; death rate, 1 in 3,162. Total number ether administrations, 407,553; deaths, 25; rate, 1 in 16,302." Making the death rate about five times greater in chloroform anesthesia than ether.

I cannot accept these statistics as complete, because all cases of deaths reported are counted, while only hospital statistics are compiled to show the number of administrations. This is plainly an incorrect view, showing that the statistics are not right in either case. These statistics do show that hospital patients, being more often addicted to the use of alcohol than patients in private practice, give us a higher death rate, and have taught us to be careful in using chloroform in these cases. I do not have the least idea that anesthetics are the cause of more than 25 per cent. of the deaths attributed to them, for we must remember that people die at all times and circumstances, and the administration of an anesthetic will not keep them with us always.

I wish to urge upon members of this Society to give chloroform its proper place among anesthetics; carefully selecting the anesthetic to suit each individual case, and to get out of the routine use of any one anesthetic.

Sixth and K streets.

THE RECENT SMALLPOX EPIDEMIC IN MODOC COUNTY.

By Bradford Woodbridge, M.D., Alturas, Cal.

There are, perhaps, no other communities in California, situated so far from the centers of population and the main highways of travel, as those of Modoc county. The distance from Alturas, the county seat, to Reno, the nearest point on the transcontinental railroad, is 180 miles, and to Redding, the nearest railroad town on the west, it is 200 miles. The county is sparsely settled, the population being less than 5,000 in an area of 4,500 square miles. Having in view these facts, together with the consideration that no case of smallpox had been reported in the State for nine months, it seems somewhat remarkable that an outbreak of the disease should occur in this place.

On the 20th of April last, Dr. A. Gibson, of Cedarville, announced that there was a case of variola in his town. The patient was a young man named Sullivan, a resident of the neighborhood. He had recently traveled about the county to some extent, but had not been in any railroad town, nor, so far as he knew, had he come in contact with any person who had been exposed to smallpox. Within two weeks after the appearance of the first symptoms in this man, three other persons in the town became similarly affected.

Experience shows that the people of country towns are slow to admit the existence of contagious disease, and especially of smallpox, in their midst, and in the present instance, doubts were expressed on all sides as to the real nature of the malady. At this juncture, Dr. Geo. M. Kober, of Fort Bidwell, and the writer were called upon to inspect the cases. On their confirming Dr. Gibson's diagnosis, the people woke up to the situation, and thereafter no means were neglected which might help stay the spread of the plague. Strict quarantine measures were enforced, and vaccination and revaccination were insisted upon and very generally adopted, with the result that but one more case developed in the immediate neighborhood.

Meantime there were reports that the disease had made its appearance at Willow Ranch, a village about 50 miles distant from Cedarville. Six days prior to the time that Sullivan became affected, a young man living at the hotel at Willow Ranch, had exhibited symptoms of a disease which the two physicians who attended him had pronounced "chicken-pox." After a week's sickness he died. Previous to his death his sister, living in the same house, had contracted the malady. Notwithstanding these facts, arrangements were made for a public funeral, and it was only through the efforts of Dr. B. Daly, of Lakeview, who, though he had not seen the cases, suspected the nature of the disorder, that the ceremony was dispensed with. No quarantine was placed on the house, however, and the neighbors flocked thither to visit the sick and to condone with the bereaved.

On the 23d of May, a County Board of Health having been organized, Dr. Geo. M. Kober and Dr. G. P. Bissell were appointed commissioners to visit the Willow Ranch district for the purpose of determining the nature and extent of the eruptive disease prevailing in that vicinity. These gentlemen visited nine families and saw 13 cases which they delared to be smallpox, ranging in severity from the mildest varioloid to variola of the most malignant type.

On this announcement, in addition to the precautionary measures which had already been adopted, disinfecting stations were placed on all the roads leading from the infected districts, and no one was allowed to leave such a district without undergoing thorough disinfection of his person and fumigation of his clothing and baggage. The good result of these measures is evinced when it is stated that after they went into effect, no case appeared outside an infected district. For fifty days there was no relaxation of vigilance, and not until the last case was out of quarantine were the disinfecting stations discontinued.

As nearly as can be ascertained, there were altogether 50 cases of the disease in the county, 45 of them being in the Willow Ranch district. There were but two deaths. The youngest child attacked was aged 2 years, and the oldest person 88 years.

An interesting point in connection with the epidemic relates to the introduction of the contagion. With no cases of smallpox nearer than Chicago, how did the germs of the disease find their way into the isolated villages of Modoc county? Dr. G. W. Pleasants, of Willow Ranch, gives the following plausible explanation: About two weeks before the first appearance of the disease, a gentleman traveling through the county, who had come directly from Chicago, stayed over night at the hotel at Willow Ranch. While there he lost a woolen mitten, which was found in the house a few days later. Nine days after the discovery of the mitten, the young man already mentioned exhibited symptoms of smallpox. Within a week two other persons living in the house also became affected. The gentleman from Chicago stopped one night at a hotel in Alturas, at which Sullivan spent the night twelve days before he was taken sick. Dr. Pleasant's theory is that the traveler introduced the contagion, and that the mitten which he left at the Willow Ranch hotel was an infected article.

From observation of this epidemic, the following practical conclusions have impressed themselves on my mind:

1. The mere isolation of a community is no safeguard against the invasion of contagious diseases.
2. Every village and town should have a health officer or a board of health, as provided by law, so that no time may be lost in taking the active measures necessary to stamp out incipient epidemics.
3. The responsibility of the physician in making an early and correct diagnosis in cases of contagious diseases cannot be overestimated; the neglected spark kindles the conflagration.
4. In vaccination and revaccination, together with rigid quarantine, we have thoroughly efficient means for the control of epidemics and threatened epidemics of smallpox.

A CASE OF A CHILD CRYING IN UTERO.

By Jas. A. Simpson, M.D., San Francisco, Cal.

Read before the California Academy of Medicine.

I desire to give a brief report of a case of the crying of a child *in utero*, in-so-far as I am able to ascertain, a rather rare occurrence in obstetrical practice.

On May 16, 1894, I was associated with Dr. Wemple, of this city, in a case of confinement, in South San Francisco. The mother had been in labor for some hours, the cervix was well dilated and the breech presenting. The natural forces seemed insufficient to effect delivery, and it was decided to perform extraction. Accordingly, the mother was anesthetized, the hand introduced and one foot brought down.

As soon as the foot appeared at the vulva, the cry of a child was distinctly heard by all present. The sound was somewhat muffled and seemed as though it came from under the bed. The cry was repeated a number of times, but ceased as soon as the head engaged in the superior strait.

Delivery was effected as rapidly as was consistent with safety to mother and child. The latter was born asphyxiated, but soon revived, breathed, and cried again. There was no evidence of liquor amnii or mucus having been drawn into the air passages. The child is now alive and well.

The explanation of this phenomenon is simple enough, for in the operation of bringing down the foot air entered the uterus and the child breathed and was so enabled to utter the cries.

In my limited researches on this subject, I have been able to find but few such cases reported in medical literature. On the 6th of February, 1894, Dr. Grandin reported a somewhat similar case to the Obstetrical Society of New York. In that case version was per formed, but in all other respects the case was similar to the one just reported. In the discussion that followed, four other members each reported a case, and an important feature in these four cases was that in two the child perished during delivery. Dr. Grandin's case, with the discussion, may be found in the April number of the *New York Journal of Gynecology and Obstetrics.*

Another case of this kind was published in May, 1887, in the *Medical Press and Circular.* In this case the vertex presented and the forceps was applied. It is stated that the crying continued until the head was outside the vulva, which seems to me somewhat remarkable, as I scarcely see how the children could cry while the head was passing through the pelvis.

In a medico-legal way this subject may be of some importance, since the fact that a child has breathed, when proved by *post-mortem* examination of the lungs, is considered proof positive that it had had an independent extra-uterine existence. In the two cases that died during delivery this would certainly be an error, for had the lungs been examined evidence of respiration would have been found, and yet both were born dead.

Butte and Kentucky streets.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By Wallace A. Briggs, M.D., Sacramento, Cal., and

Henry Gibbons, Jr., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medica College, San Francisco, Cal.

Ligature of the Broad Ligaments in Uterine Fibroids.—Dr. H. Martin ligatures the broad ligaments through the vagina, cutting off a larger or smaller part of the ligament, according to circumstances. Sometimes he includes only the lower part of the one or of the two ligaments, with the arteries and uterine nerves; sometimes, on the contrary, he completely ligatures one of the ligaments above the uterine and ovarian artery, and ties only that portion of the other containing the uterine artery. Dr. Martin makes the following report of the five cases in which he has performed this operation: (1) Uterine fibroid; abundant hemorrhage; rapidly growing tumor. Ligature of one ligament; cessation of hemorrhage. Examination several months after showed that the tumor had neither increased nor diminished in volume. (2) Large fibroid; severe pain; constant and abundant hemorrhage. The patient unable to leave her bed. Complete ligature of one ligament; partial ligature of the other. Immediate cessation of pain and hemorrhage. Three months afterward the tumor had nearly disappeared. (3) Interstitial fibroid: abundant hemorrhage. Ligature of one broad ligament. Diminution of hemorrhage, but no decrease in the size of the tumor. (4) Patient 36 years old; partial ligature of the two broad ligaments for fibroid, accompanied by hemorrhage. Five months afterward menstruation had become normal and the tumor had greatly diminished in size. (5) The last case is the most interesting, The fibroid extended to the umbilicus, with frequent and severe hemorrhage. Laparotomy was performed in the hope of removing the tumor, but adhesions were so numerous, and the pelvis so entirely filled by the fibroid, that it was necessary to close the abdomen without further intervention. After the patient's recovery from this operation, the two broad ligaments were tied above the principal vessels. Since that time the patient has menstruated regularly and the tumor has decreased three-quarters in size.—*Gazette de Gynécologie.*

Dangers of Intra-Uterine Injections of Glycerin.—About two years ago a German obstetrician, M. PELRER, advised intra-uterine injections of glycerin as an absolutely inocuous and rapidly efficacious method of bringing about premature labor. But MEULLER (*München. med. Wochenschr.*) and PFANNENSTIEL (*Centralbl. f. Gynäkol*) have simultaneously published observations tending to show that these injections are not efficacious and are extremely dangerous. Almost immediately after the administration of the injection Müller's patient was taken with violent diarrhea, uncontrollable vomiting and a severe chill, which lasted nearly an hour and was followed by pain, dyspnea and rise in temperature. Labor did not occur until the next day, after the temperature had fallen and again risen to 40° C. The child lived only two hours, and the patient was delivered of another child (still-born) on the following day, after a repetition of the same symptoms. Repeated examination of the urine revealed intense hemoglobinuria. Almost the same symptoms were observed in Pfannestiel's case, except that the urine contained a large quantity of albumin, and labor did not occur for several days after the glycerin injection. Both patients recovered. The two authors agree as to the presence, in each case, of glycerin intoxication, the possibility of which has been shown by the experiments of Robert, Schwalm and Lebedeff.—*Rèvue Médicale*, May 6, 1894.

SURGERY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal., and

G. F. SHIELS, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

Neuromimesis.—Two Cases in which the Hip-joint Had Been Held Fixed for Nine Months.—MR. W. G. SPENCER says (*Lancet*, April 28, 1894): These two cases are worthy of note, since for nine months the hip-joint in each was believed to have been seriously injured. Sir James Paget, in his Clinical Lecture on Nervous Mimicry,[1] has described the group to which these patients belong. The first case was that of a strong, healthy sailor, 17 years of age, who had been thrown down by a lurch of the vessel in the North Sea. He had been treated during 9 months as for an injury of the hip-joint by rest and liniments. He expressed himself as very anxious to regain the use of his leg. The other, a young man 20 years of age, was also perfectly healthy. Last August an accidental kick just above the left pubic spine had caused an abrasion, followed by an abscess. The place was marked by a superficial scar. He had formed the notion that the left hip had been dislocated by the kick and was still out of joint. These two cases were identical in character. Both patients complained of a fixed hip-joint and of pain along the inner side of the knee. In both the limb was held rigidly extended at the hip, neither rotated in nor out, and neither abducted nor adducted, a position not obtaining in disease or after injury. The length of the affected limb and the great trochanter, in respect to position and touch, corresponded with that of the opposite side. Firm pressure over the front of the joint caused no pain. Sufficient nitrous oxide gas was given to the first patient to overcome resistance, and the free motion of the hip-joint was continued as he recovered conciousness. In the second case I diverted the patient's attention for a moment, and, having commenced the flexion, carried the limb by main force up to the abdomen. The head of the bone moved freely in the joint, and both patients were able to stand on the other leg and flex the affected limb to less than a right angle with the trunk. After this free movement both seemed convinced that there was nothing wrong with the joint—at least, I have not seen them again.

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[1] Clinical Lectures and Essays, second edition, 1879, p. 210.

Functional Troubles Following Old Fractures of the Patella.—After a careful study of this subject, CHOUX (*Rév. de Chir.*), comes to the following conclusions: (1) The functional troubles consequent upon old fractures of the patella are either insufficient extension or flexion. (2) The difficulty in extension is due less to the atrophy of the triceps muscle than it is to the momentary physiological inability of the muscle to act efficiently upon the lower fragment of the patella. (3) The difficulty in flexion is dependent on the fibro-articular thickenings, which are themselves due to the retraction of the patella tendon and to the method of union between the fragments. (4) Of the five modes of union, as generally divided, two types alone are capable of interfering with flexion; they are the short, but stiff, osseous or fibrous union and the fibrous union with two to five centimeters' separation of the fragments. (5) The prognosis in incomplete extension may be doubtful for several years, but restoration of function is generally the rule. Intra-osseous suture of the fragments is indicated in cases where the spontaneous reëstablishment of function is not realized after a reasonable length of time. (6) In regard to partial ankylosis resulting almost always from short, rigid union between the fragments, either osseous or fibrous, but increasing the length of the patella two or three centimeters, he considers the removal of one of the two fragments the only possible means of overcoming the functional difficulty, unless these types are transformed, as often happens, into types more favorable to flexion. (7) The articular inflammatory thickenings, which often disappear, should be held under observation for from twelve to fourteen months, and are eminently fitted for the hydrothermal treatment as used in the hospital of Bourbonne.—*American Journal of Medical Sciences*, June, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

The Treatment of Epilepsy by Tenotomy of the Eye Muscles and by Other Surgical Means.—After discussing the history of the different surgical treatments that have been used at various times in the treatment of epilepsy, DR. CASEY A. WOOD formulates the following conclusions: (1) Heterophoria in some form, latent or manifest, can be shown to exist as an ocular condition in fully 95 per cent. of all individuals, (2) Alone, and when associated with amentropia, it is not an uncommon cause of so-called asthenopia. (3) In the latter case the correction of the accompanying refractive error, in the large majority of cases, relieves all the symptoms set up, both by the ametropia and muscular anomaly; when it does not, the heterophoria may be said to be responsible for the asthenopia. (4) It is highly probable that when epilepsy is in part or wholly the result of eye-strain *other* evidence of the latter is present. (5) It must follow from the foregoing that in eye treatment of epilepsy of any decided degree the correction of the heterophoria is the first and most urgent duty of the ophthalmologist, and that in cases where both are corrected at the same time it is fair to suppose that the results, if any, are due to the ametropic correction, (6) In cases of epilepsy with heterophoria and emetropia, or where the correction of refractive errors has failed to relieve the asthenopic symptoms and the production of orthophoria is followed by cure of the epilepsy and the asthenopia, it is just to say that the operation on the eye muscles or treatment of them has produced the effect of stopping the convulsions. (7) In the absence of ocular symptoms, apart from the epilepsy, an operation upon the eye muscles stands in the same therapeutic relation to a cure or relief of the disease as do other surgical procedures that have during the past century been in vogue, such as tracheotomy, setons, ligature of the vertebral arteries, trephining, oöphorectomy, circumcision, castration, the actual cautery, the resection of stray scars, and so on. (8) These operations bring about a cure or relief of the epilepsy (both idiopathic and hystero-epilepsy) by their powerful mental effect upon the patient—a truth long recognized by neurologists. (9) Genuine cures of epilepsy by eye treatment of any kind must necessarily be confined to those cases where a faulty ocular apparatus acts as a peripheral irritant. It remains yet to be shown that anomalies of the extrinsic muscular portion of that apparatus are to any large extent responsible for seizures of epilepsy. (10) The eye treatment of epileptics who present signs of ocular distress has not received that attention which the importance of eye-strain in the category of reflex irritants seems to call for. The eye should be carefully examined in every case of epilepsy where asthenopic symptoms are present or suspected. (11) I question the wisdom of encouraging the profession, and through it the laity, to believe that *every* case of idiopathic epilepsy is a suitable one for eye treatment, but prefer to say that only those cases are fit subjects, in the proper scientific sense, for eye treatment whose visual organs are palpably the source of irritation, giving rise to symptoms generally included under the term eye-strain. (12) When all remedies fail, some such operation as Reynolds suggests—easy to perform, perfectly safe, and yet of a severity and character tending to make a lasting impression on the patient's mind, is indicated. I would suggest the removal, at intervals, of skin from various parts of the body, the denuded spots being allowed to heal by granulation.—*New York Medical Journal*, July 14, 1894.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. Simmons, Jr., M.D., Sacramento, Cal.

Intravenous Injections of Corrosive Sublimate in Syphilis.—Dr. Guido Backlli has found, in his experimental work upon animals, that the fears as to the results of these injections, so far as concerns the blood, are unfounded. In two patients suffering from cerebral syphilis, where the ordinary methods of internal administration, ununction and hypodermic injection in large doses had failed, the new treatment gave brilliant results. The usual solution is as follows: Corrosive mercuric chloride, 1: sodium chloride, 3: distilled water, 1,000. The skin must be treated with careful aseptic methods. A vein in the elbow, the back of the hand, or the leg is selected; the vessels are then distended by a bandage, proximally placed. The needle of the filled syringe is inserted, and the injection made into the vein; the absence of pain and subcutaneous swelling indicates that the vein has been entered. In one case, the metallic taste of mercury was noted by the patient in a few seconds. A flow of saliva followed in 5 or 6 minutes. The initial dose was 1/64 grain, and it was increased to ⅛ grain *per diem*, which had not been exceeded. The advantages are: (1) The small quantity of the remedy necessary. (2) The possibility of rapidly combatting the symptoms which are due to the direct blood poisoning caused by the syphilitic virus. (3) The prompt action of the remedy upon the walls of the blood vessels, which are the favorite seat of syphilitic degeneration. (4) The immediate carrying of the drug in the blood current to all tissues and organs.—*Berliner klin. Wochenschrift—American Journal of Medical Sciences.*

Ichthyol in Genito-urinary Affections.—H. LOHNSTEIN (*Allg. med. Central-Zeitungen*) arrives at these conclusions: (1) Ichthyol in hot solutions, for urethral use, (.5 to 2 per cent.) is very useful in acute urethritis, especially in those cases where the mucous membrane is very sensitive. (2) In subacute urethritis, where the lesions are circumscribed, local applications of ichthyol (with the aid of the endoscope) render great service. (3) Ichthyol suppositories, in the majority of cases, cause the inflammatory symptoms to disappear in the course of a prostatitis. (4) In chronic urethritis, with infiltration, ichthyol by itself is inefficacious; but, associated with the mechanical treatment, or alternating with it, it appears to be of great benefit. (5) Administered internally, ichthyol does not have any beneficial effect on nephritis or pyelitis.—*Nouveaux Remèdes*, June 8, 1894.

Treatment of Impermeable Strictures of the Urethra.—The difficulty that is frequently encountered by surgeons in penetrating very tight urethral strictures has suggested a method of dilating them which others may find of service in their practice. It consists in passing down to the site of the stricture a catheter shaped as a simple cylindrical tube, open at both ends—an ordinary catheter, from which the eyed end has been cut off, and the edges carefully smoothed, does very well. And through this as a guide, introducing the largest instrument, from a filiform bougie upwards, which can be made to penetrate the stricture.—CHARLES H. WADE, in *Lancet.*

Another most successful means of permeating very tight urethral strictures is "catheterism on physiological principles," as advocated by Mr. Gay, in the *Lancet* for November 16, 1878.—*Lancet*, May 26, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Bismuth in Gastric Disease.—MATTHES has investigated, both experimentally and clinically, Fleiner's method of treating irritative diseases of the stomach with large doses of bismuth. The results of the treatment were very successful, especially in lessening pain. From experiments on dogs the author shows that ten to twenty minutes after ingestion the bismuth sinks to the bottom of the stomach, whereas several hours later it is found spread over and fixed to the stomach wall, becoming intimately mixed with mucus. Even with a full stomach a large portion is found similarly deposited. Against the action of chemical agents on the stomach wall this deposit of bismuth is most resistant. In men, shortly after ingestion of bismuth, the water used for washing out the stomach returns clear, but if later the stomach contents be expressed, bismuth with mucus is removed. Experimentally, bismuth is shown to increase the secretions of mucus. To determine the action of bismuth in cases of erosion, etc., of the stomach, defects were made experimentally in the stomach mucous membrane of dogs and rabbits, and bismuth was then administered. In some cases the results were very indefinite, but in two experiments positive results were obtained. In one case an adherent crust was found acting as a protection to the defect, and sections from both cases showed healing ulcers. In the case of the crust, bismuth crystals were found in the granulation tissues of the healing ulcer. No symptoms of bismuth poisoning occurred. Experiments thus show that bismuth adheres to the defect in the stomach wall, and that healing may take place in a crust so formed; this crust, however, is not always present. Comparison with control, animals showed that in those treated with bismuth the defects healed more rapidly. Digestion can go on while the bismuth deposit is present, although in *artificial* digestion the pepsin is carried down by the bismuth, and in this way digestion is hindered. The author says, that both experimentally and clinically, Fleiner's method of treatment is practically and theoretically correct, with the exception of the question of position (in reference to the site of the ulcer), which he shows not to have any influence in regard to the subsequent disposition of the bismuth.—*British Medical Journal.*

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

The Microbic Origin of Chorea.—DR. CHARLES L. DANA, of New York, concludes that the seat of the trouble in chorea is the blood vessels and blood of the brain, with secondary changes in the brain tissue—the cause being some microbe or toxic substance, or both. In April, 1890, he published in *Brain*, an article on the pathology of chorea in which this was considered. In 1891, Dr. Henry J. Berkeley published in the *Johns Hopkins Hospital Reports* (vol. ii, No. 6), an article upon the germ causation of chorea. According to these authors, changes are found in the cortex and subcortical tissue of the cerebral motor areas and adjacent meninges. Dana details a case of Sydenham's chorea in which chronic leptomeningitis of the covexity hyaline bodies in the cortex, slight meningo-encephalitis, together with slight meningitis of the upper part of the spinal cord were found, and bacteriological examination showed diplococci in the proliferating tissue between the meninges and cortex with hyaline bodies in the cortex. Richter, in the *Western Lancet* (vol. xii, p. 529) refers to cocci found in the blood in a case of chorea. By others, bacilli have been found in the tissue and fungi in the pia mater. The case referred to by Dana, was a man of 34, who had a history of rheumatism at 10, and chorea began at 14. Severe recurrent attacks of chorea with intervals of several years, during which slight chronic symptoms were present, till 34. Patient had no headache, the mind was clear; viscera normal; no elevation of temperature. At the autopsy, the dura mater was normal. No excess of fluid in the ventricles. Brain congested. Over the convexity the pia and arachnoid were thickened and granular from the base of the first frontal convolution backward to the occipital lobe. Some thickening and congestion of the pia about the medulla and cervical part of the spinal cord. *Microscopical examination:* In the superior parietal lobule and upper central convolution, chronic proliferative thickening of the pia without exudate. Degeneration, with cellular infiltration of superficial or neuroglia layer of the cortex. Vessel walls slightly thickened. Numerous large, hyaline masses in the pia and just below it, diminishing in number down to the second layer of the cortex. These were found in those parts of the brain hardened by alcohol alone. These masses did not stain, were irregular in size, averaging $\frac{1}{100}$ inch in diameter, sometimes around but not in the vessels; they were considered as indicating a morbid condition of the nerve tissue, although more or less due to the method of preparation. In the parts hardened in Müller's fluid' these bodies were not found, but different kinds of hyaline bodies were found in the second and third layers of the cortex. These were round or nearly so, translucent; did not stain by carmine, hematoxylon or osmic acid. They were $\frac{1}{1000}$ inch in diameter, and in the center of each was a nucleus. They appeared to be cells undergoing degeneration and bore no special relation to the vessels. The regions of degenerative change were where the microbes were found. There were no vascular changes. These conditions were mostly in the superior parietal and upper central convolutions. A few hyaline bodies and increased vascularity were found in parts of the lenticular nucleus, the claustrum and the external capsule. The pons and medulla showed but little that was abnormal. In the cord, meningitis with vascular changes in the upper part, especially surrounding and affecting the nerve-roots as they left the cord and medulla. *Bacteriological examination:* A few isolated diplococci on the inner surface of the meninges and in the cortex immediately below. These were one-half the diameter of a red blood corpuscle.—*American Journal of Medical Sciences.*

The Spinal Cord in Syphilis.—During the eight years that GERHARDT conducted the second medical clinic of the Berlin Charité, he observed 39 cases of cerebral syphilis. He quoted Virchow as follows: "Brain syphilis is as varied as skin syphilis, and spinal cord syphilis as varied as brain syphilis. Syphilis of the verterbræ is uncommon and usually provoked by some traumatic condition. The nerve substance of the spinal cord is less often the primary seat of syphilis than the blood vessels and meninges. Syphilis of the spinal cord follows the primary infection in a comparatively short time; cases have been observed three months after the initial sore. Then again syphilis of the cord may not occur until from ten to twenty years after primary infection. The blood vessels play an important role in spinal syphilis. In such cases, sudden paraplegia is not uncommon. When syphilis implicates the vertebræ, it shows a predilection for the cervical vertebræ. Gerhardt had also, during eight years, 102 cases of tabes. About one-half of these were syphilitic. He believes that many of these cases of syphilitic tabes are amenable to treatment if taken early enough.—*Münchener med. Wochenschr.*

Purulent Typhoid Cholecystitis.—In a previous communication (*Semaine Medicale*) GILBERT and GIRODE referred to infection arising from the bacilli of typhoid fever ascending into the biliary passages, and which constituted the chief action of typhoid fever on the liver. They present a new fact in corroboration of their original observations. A woman suffering from typhoid fever presented in the course of the affection, a swelling in the hepatic region corresponding to the gall bladder. During the convalescence of the patient, the swelling became less pronounced. Five months after the attack of typhoid fever, cholecystectomy was performed for a calculous cholecystitis. The gall bladder contained a large calculus and pus. In the latter the bacillus of Eberth was found, and pure cultures were made. The mucous membrane lining the gall bladder was thickened, and on microscopical examination, after appropriate staining, the typhoid bacillus were found in large numbers. This case, demononstrated not only that suppurative inflammation of the gall bladder may be provoked by the typhoid bacilli, but that a suppurative inflammation may develop long after convalescence from typhoid fever.

Two New Signs of Dilatation of the Stomach.—It is not difficult to diagnose gastrectasia when it has attained any degree of development, but at the inception of the affection the difficulties which beset the physician are many. Many of the methods of diagnosis are impracticable in private practice. M. AUFRECHT directs attention to two new signs obtained by percussion. In percussing a stomach which has commenced to dilate, by means of a pleximeter, one obtains at certain points in the gastric region, a dulness more or less complete in *lieu* of the usual tympanitic tone. If the pleximeter is kept at the point of dulness and feeble percussion is made, after waiting a few seconds the dulness will be found to have been replaced by a tympanitic tone. This phenomenon is explained by contraction of the walls of the stomach on account of its hypertrophied muscular coat which is constantly present in gastrectasis. The second sign is a cracked-pot sound (*bruit de pot fêlé*) which is obtained in the immediate vicinity of the dulness already described.—*Semaine Médicale.*

Tabetic Arthropathies.—DR. GUSTAV SINGER refers to the symptomatology of tabetic articular affections. Their occurrence is spontaneous and sudden' without pain and fever. They show a tendency to articular effusions, deformity, luxation, and a disappearance of the joints by resorption, as well as the formation of large masses of bone in the environments of the joint. Relative to the frequency of tabetic anthropathies opinion is divided. Charcot observes that in every ten cases of tabes, spontaneous fractures or joint affections occur. Marie observes their frequency in from four to five per cent. of the cases; whereas, Erb noticed only two cases of anthropathy in fifty-six cases of tabes. The two types of anthropathy differentiated by Charcot are atrophic and hypertrophic, the latter type being included under the designation anthritis deformans. Virchow's conception of the affection is essentially that of a deforming joint affection, with primary destruction of the epiphyseal cartilage. Charcot maintains that the tabetic anthropathies are the result of atrophy of the anterior horns in the spinal cord, which he considers to be the trophic centers of the joints. Many writers have endeavored to show the relation between the anthropathies and peripheral nerve lesions; indeed, they have often noted atrophy of the nerves as they entered the nutritive foramina of the bones. The knee joint is most frequently involved; here belong genu recurvatum, valgum and varum of the usual forms. Subluxation backwards is infrequent. It is important to differentiate tabetic from other joint affections. The pronounced articular changes, with limited impairment of function and abnormal passive mobility without pain, is characteristic of anthropathy.—*Wiener Med. Presse.*

Transient Aphasia of Pneumonia.—M. CHANTEMESSE has observed in the course of many infectious maladies, notably in pneumonia, transitory aphasia without any discoverable lesion of the nervous system. In pneumonia the aphasia becomes manifest at the end of the second or third day, and is preceded ordinarily by cephalalgia, dizziness and formication in the right arm and right half of face. In some instances the latter symptoms are clearly hemiphlegic. The aphasia may appear brusquely without loss of consciousness; whereas, in other instances, it may assume the veritable picture of an apoplectic attack. This form of aphasia corresponds with the form usually known as ataxic aphasia. The intelligence, at first obtuse, recovers itself after a few hours.

One will observe in other cases the occurrence of paralysis of the lower branch of the right facial nerve. If hemiphlegia attend the attack, it can be complete; but it more often is incomplete and limited to the tongue, face, and right upper extremity. The sensibility and reflexes are ordinarily but little modified. In the more pronounced cases one can observe certain vasomotor phenomena, as redness, edema, and elevation of temperature in the paralytic zones. The paralytic accidents just described are not modified by the course of the pneumonia, nor do they bear any relation to the severity of the disease. The aphasia persists 4 or 5 days at the most, although it may disappear after 48 hours. The facial paralysis disappears usually with the aphasia; but the paralysis implicating the extremities may survive the aphasia. The pathogenesis of the aphasia is very obscure. We cannot attribute it to any material lesion, since the cure is so rapid. The cause must probably be sought for in the vasomotor system, which influences the contractility of the cerebral blood vessels. *Union Médicale.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Delirium Following Operations on the Eye.—Dr. Enrique Lopez, of Havana, Cuba, has recently published an article treating of the delirium which sometimes develops in individuals who have undergone operations for various diseases of the eye. Two forms have been described: a delirium of exaltation, somewhat similar to that produced by belladonna, and a delirium of persecution. The delirium has been attributed to many different causes. Some think that the action of atropin exerts a positive influence in producing it; others ascribe it to the occlusion of the eyes by the bandage after the operations; others, again, think that the weakness consequent upon the diet is an important factor in bringing it about. Many authorities say that alcoholism, frequently present, is of itself sufficient to produce the delirium. In the observations made by the writer the facts incline him to the belief that the delirium is only observed in individuals predisposed to insanity, with or without alcoholism, and in whom there only exist eccentricities of character, which may have passed unperceived by the physician—the mania, until then latent, breaking out after the operation, favored by circumstances which contribute to excite his imagination, such as the fear of losing the sight, diet, occlusion of light, etc. The access of mania is ordinarily temporary. It may last a few hours or several days, but it finally disappears completely. It varies in intensity from vague fears, and slight, hardly appreciable troubles of the intellect to a furious delirium which may require the use of the strait-jacket. If in a moderate attack the patient be convinced of the success of the operation by the uncovering of the eye, the delirium may sometimes be put a stop to; but in a more pronounced case this has no effect, the patients frequently saying that they see nothing, even after they have been shown that they can distinguish fingers, can read, etc. This delirium consequent upon operations is, therefore, only a form of mania in individuals already mentally alienated, or in whom the intellectual trouble was until then in a latent form. Dr. Lopez has always observed it in the old and atheromatous, which has made him think that this disease of the vascular system plays an important rôle in the production of cerebral troubles, and subsequently of maniacal paroxysms. It is not strange that the cause of the delirium in question should be charged by some to alcoholism, which is a frequent factor in the production of atheromatous degeneration; in cases of this nature it takes the form of delirium of persecution. In conclusion, the writer cites three cases as examples of the maniacal forms he has observed. In the three forms of delirium the patients were atheromatous, the only circumstance which was common to them. In one case only was there addiction to liquor; in the second case there was hereditary disposition to insanity, and in the third case the patient was known to possess a melancholy temperament. The author thinks that the complication of the delirium might possibly be prevented by prescribing the bromide of potassium, associated with the hydrate of chloral, before and after the operation.—*International Medical Magazine.*

Neurasthenia and Melancholia.—Dr. Boissier has made a study of 60 cases of neurasthenia and melancholia, selecting only such cases as showed the least hereditary taint, and which came nearest to the pure melancholic condition without hypochondria or persecutory delusions, with the view of ascertaining the relations of neurasthenia to depressive insanity. He classified them, as nearly as possible, according to their graduation from the neurosis to the psychosis. With regard to the etiology, melancholia appears to be a stage of aggravation of neurasthenia. An examination of acute cases of melancholia reveals all the physical and psychic symptoms of the two disorders, but in a more intense degree than the ordinary chronic cases. In depressive melancholia all the symptoms of nervous exhaustion may exist and be combined in the same patient. Some, however, are aggravated, others unchanged, others still are modified or diminished by the immobility imposed by the psychosis. As regards the physical characters, the general resemblance of the two conditions is such that it is difficult to point out the difference with certainty, at least as a general rule. In stuporous melancholia, which, in a measure, is the crystallization of the neurasthenic condition, the patient loses all his energy, scarcely reacts at all to external impressions, and is wrapped up in his automatic sensations and fixed impressions, that form the central point of his insanity. The distress and extreme emotional nature of the neurasthenic are with his general lack of energy, the factors of his timidity and lack of self-confidence. Though this emotivity is less pronounced in melancholia, it exists, but is the less apparent the more depressed the patient. The outward signs, the facial expression, etc., are to some extent lacking. Even in stuporous cases the patient dreads any intercourse with strangers, as indicated by the tremor present. In other cases one can still note by the pulse or the flushing of the brow the cardiac irritation produced by the emotion. In the anxious hyperesthetic forms, on the other hand, where the depression is not so profound, the emotivity predominates, and the least external manifestations, or internal phenomenon, arouses in the subject the most terrible distress. The writer speaks of the unequal failures of the energies of the various faculties as characteristic of neurasthenia, while he regards the equal general deficiency of the whole, which is subject to variations in intensity, as differentiating melancholia from simple, depressed nervous exhaustion. The one is a paretic, the other a paralytic. Dr. Boissier concludes as follows: Neurasthenia is a morbid entity, of which the constant symptoms—headache, insomnia, distress, tachycardia, disorders of general sensibility, depression—are in relation with those of melancholia.—*Journal de Médicine de Paris.*

their mediate and indirect action through the toxines they secrete. From a clinical point of view they may present themselves at two different periods. During the febrile stage the disorder ordinarily takes the form of an acute delirium. During the post-febrile stage, or during convalescence, we find the so-called asthenic psychosis present; this is a more or less variable mental condition, consisting usually of a mental confusion, stupidity, clouding of the faculties, a pseudo-dementia. An intermediate form between these two may possibly be admitted to exist. The visceral psychoses are in reality genuine insanities from auto-intoxication. It may be said that where the intoxication is acute it shows itself as an acute toxic delirium, resembling alcoholic delirium, as in uremic insanity, when the intoxication is chronic, it generally induces a melancholic condition. Some cases resemble more or less paretic dementia. General or local anti-infectious antiseptic treatment is found to give excellent results. Although it is not possible to formulate a definite therapeusis, there are enough facts to show that in the infectious or auto-toxic insanities one must resort to the treatment of the infection or the auto-intoxication to relieve the mental disorder.—*Progrès Médical.*

The Influence of Diseases of the Ear upon the Development and Course of Insanity.—DR BJELJAKOW has recently reported the results of observations made in hospital in St. Petersburg on cases of insanity in which these was a marked inflammation of the middle ear. In the course of four years he had made 135 *post-mortem* examinations, and these showed 17.12 per cent. to have been suffering from internal otitis. Of these cases one was melancholia, one paranoia hallucinatoria acuta, eight paranoia hallucinatoria chronica, two secondary dementia, three epileptic insanity, four general paralysis, one acute delirium, one senile dementia and three hebephrenia. At the conclusion of his paper, the writer says that an inflammatory process of the internal ear frequently produces insanity, accompanied by hallucinations, which form of insanity often terminates in secondary dementia in unfavorable cases. The unilateral auditory hallucinations are usually due to an increased irritability of the cortical centers transmitted through the nerves of hearing. Sometimes the hallucinations are bilateral, which would tend to prove the existence of an auditory center in each hemisphere. Auditory hallucinations, due to disease of the organ of hearing, frequently excites hallucinations of taste, smell and general sensibility. In many of the cases there appeared to be a hyperesthesia as regards the subjective auditory perceptions, while the sensibility to hearing outward sounds was generally diminished. Salivation, which sometimes accompanies suppuration of the middle ear, is probably caused by irritation of the chorda tympani through nerves of the tympanic plexus. These patients also frequently suffer from attacks of precordial melancholia and pain about the pericardium, which may be explained as due to irritation of the auricular branches of the vagi nerves, and the eccentric perception of this irritation by the auditory brain centers. Disease of the internal ear sometimes seems to be the cause of epilepsy, and may bring about symptoms resembling general paralysis. On the other hand, otitis may cause unilateral hallucinations of hearing in general paralysis, which, however, are rarely met with in this disease.—*Journal of Mental Science.—Medical Review.*

FORMULÆ.

By Geo. B. Somers, M. D., San Francisco, Cal.

An Antiseptic Varnish.—Berlioz gives the formula for an antiseptic varnish which he calls "sterisol."

Gum lac (purified)	℥ix
Powdered benzoin	ʒiiss
Tolu balsam	ʒiiss
Chrystallized phenic acid.	℥iii
Essence of cinnamon	
Saccharin	āā ʒiss
Alcohol	*ad* O ii

The employment of this varnish is indicated wherever there is an abrasion of the mucous membrane, as in diphtheria, mucous patches, hernia, etc. It adheres to the mucous membrane as well as to the skin, over which it forms a thin pellicle.—*Medical Record.*

Chronic Pharyngitis:

Iodine	gr. vi
Pot. iodide	gr. xii
Menthol	ʒi
Glycerin	*ad* ℥i

S.—Apply with a camel's hair brush twice or thrice daily.—*Medical Press and Circular.*

PUBLIC HEALTH.

By W. R. Cluness, M.A., M.D., San Francisco, Cal.

Mortality for June, 1894.—The deaths registered in 61 town districts of the State, during the month of June, in a population of 758,247, correspond to an annual rate of 14.76 a thousand, the total mortality having been 936. 80 deaths were due to zymotic diseases, giving an annual rate of 1.26 a thousand. Of these, 9 were due to diphtheria, 16 to cholera infantum, 15 to typhoid fever, 10 to diarrhea and dysentery, 14 to cerebro-spinal fever, 9 to whooping cough, 1 to croup, 3 to intermittent and remittent fevers, 2 to scarlet fever, 1 to measles, and 0 to small-pox. 232 deaths resulted from diseases of the respiratory organs, giving an annual rate of 3.66 a thousand. Of these, 148 were due to consumption, 53 to pneumonia, 26 to bronchitis, and 5 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.28 and .828, respectively. 96 deaths resulted from diseases of the heart, 7 from alcoholism, 1 from erysipelas, 32 from cancer, and 440 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 584,027, was 15.24. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Jose, the lowest from Petaluma and vicinity.

METEOROLOGY.

Summary for June.—*Temperature.*—The normal temperature of the State for June is 71°, the average for June, 1894, was 66°; a departure from the normal of -0.5°. The highest monthly mean was 90°, at Salton, in the desert regions of Riverside county; lowest, 48°, at Cisco in the high mountain regions of Placer county; the maximum, 118°, at Salton, on the 30th; the minimum was 25°, at Boca, in the high mountain regions of Nevada county, on the 11th. The absolute monthly range was 93°; greatest local monthly range was 66°, at Orangevale; the least, 18°, at Point Lobos.

Rainfall.—The normal precipitation of the State for June is 0.31 inches; the average for June, 1894, was 0.68 inches; a departure from the normal of +0.37 inches. The greatest monthly precipitation was 3.49 inches, at La Porte, the least, nothing, at a number of stations.

Wind.—The prevailing direction of wind was westerly.

Unusual Features.—The unusual meteorological feature of the month was the continued and abnormally cool weather with unusual rains.—James A. Barwick, Director California Weather Service.

California—Tabular Statement for June, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn..........Cal.	66.2	95.0	53 0	----	----	----	----	1.38	----	----	----	----	S.W.	Southern Pacific Company.
Berkeley......... "	57.1	76.0	47.0	67.3	51.6	15 7	3	1.11	81 0	15	14	3	S.W.	Obs. University of California.
Colfax........... "	----	----	----	----	----	----	----	----	----	----	----	----	----	Southern Pacific Company.
Eureka........... "	54.0	65 0	42.0	59.0	50.0	9.0	10	1 67	95.0	5	15	10	N.W.	Weather Bureau Dept. Agr.
Fresno........... "	68.9	100	47 0	82.5	55 3	27.2	4	1.16	52.0	21	3	6	N.W.	" " "
Indio............ "	80.5	103	62.0	----	----	----	0	0.00	----	----	----	----	W.	" " "
Los Angeles.... "	63.0	83 0	46.0	74.0	52.0	22.0	1	T.	74.0	10	20	0	W.	" " "
Monterey....... "	59 3	88.0	50.0	----	----	----	0	0.00	----	----	----	----	S.	Southern Pacific Company.
Napa............ "	64.5	87.0	47.0	74.8	54.2	20.6	5	0.85	74.0	15	12	3	S.W.	Station Napa Insane Asylum.
Oakland......... "	59 5	82.0	46.0	69.4	51.7	17.7	5	0.95	73 0	17	8	5	W.	Chabot Observatory.
Paso Robles.... "	63.0	90.0	42.0	78.0	48.0	30.0	2	0.12	47.0	25	4	1	E.	Agr. Ex. Station.
Red Bluff....... "	69.0	101	46 0	82 0	57.0	25 0	7	1 00	56.0	22	8	0	S.	Weather Bureau Dept. Agr.
Sacramento. ... "	64.8	96.0	50.0	76.4	53 3	23.1	5	0.46	67 0	16	8	6	S.W.	" " "
San Bernardino "	66.0	95.0	40 0	83 0	49.0	34.0	0	0.00	62.0	23	5	2	W.	A. K. Johnson, M. D
San Diego....... "	61.0	73.0	50.0	64.0	60 0	4.0	1	0.01	76.0	23	5	2	W.	Weather Bureau Dept. Agr.
San Francisco.. "	55 7	69.0	47.0	61.3	50.5	10 8	5	0.56	83 0	13	7	10	S.W.	" " "
Santa Barbara.. "	61.4	90.0	46.0	69 7	53.0	16.7	0	0.00	68.0	21	6	3	E.	Hugh D. Vail.
Santa Cruz...... "	62.0	85.0	43.0	73.0	51.0	22.0	4	0 72	----	19	5	6	S.W.	W. R. Springer.
Yuma..........A. T.	79.4	108	55.0	95.5	63.3	32.2	0	0.00	42.0	27	3	0	W.	Weather Bureau Dept. Agr.

NOTE.—Relative humidity at Paso Robles is for 2 P. M. T. means a trace of rain. Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: AUGUST, 1894

THE COMMENCEMENTS—COLLEGE OF DENTISTRY.

The commencement exercises of the College of Dentistry, University of California, were held at Odd Fellows' Hall, San Francisco, on Thursday evening, June 14, 1894. In conformity with the change in the term of the College, which is now uniform with that of other regular dental colleges in the United States, the exercises were held at a later date than in previous years.

The address on behalf of the faculty was delivered by JOSEPH D. HOGDEN, D.D.S., the degrees being conferred by MARTIN KELLOGG, M.A., President of the University.

The following are the names of the graduates: Edward Ellsworth Baird, William Henry Cavell, McCoy Chappell, Conrad Deichmiller, John Alvin Gibbon, Gilbert Fuller Graham, Robert Frederick Gray, Walter Simpson Jewell, James William Likens, William O'Rourke, Henry Powell, Jr., Walter Judson Taylor, Leander Van Orden, Jr., M.D., Thomas Augustus Vogel, David John Vogelman, William Henry Wadsworth, Walter Irving Wilcox, Charles Calvan Wood.

The total number of students in attendance during the past session was 132, the number of matriculates being 74.

NOTES.

The American Journal of Insanity.

The American Journal of Insanity, which has been edited and published at the Utica State Hospital for the past fifty years, has lately been sold and transferred to the American Medico-Psychological Association, of which Society it will henceforth be the accredited organ. The *Journal* will be edited *ad interim* by a publication committee consisting of Dr. Edward Cowles, President of the Association, Boston, Mass.; Dr. Henry M. Hurd, Secretary of the Association, Johns Hopkins Hospital, Baltimore, Md.; and Dr. Richard Dewey, Chicago, Ill., with the last named gentleman in immediate editorial charge. Until further notice it will be published in Chicago, Ill.

Committees of the State Medical Society.

The following are the Standing Committees of the Medical Society of the State of California, for 1894–'95:

Committee on Clinical Medicine, including Diagnostics and Therapeutics—David Powell, Marysville, Chairman; J. H. Utley, Los Angeles; W. Watt Kerr, San Francisco.

Surgery and Clinical Surgery—R. A. McLean, San Francisco, Chairman; C. L. Bard, Ventura; J. F. Morse, San Francisco; G. A. White, Sacramento.

Pathology and Pathological Anatomy—J. C. Spencer, San Francisco, Chairman; C. G. Kuhlman, San Francisco; D. W. Montgomery, San Francisco.

Diseases of the Mind and Nervous System—H. G. Brainerd, Los Angeles, Chairman; A. W. Hoisholt, Stockton; M. Gardner, Sacramento. W. E. Bates, Davisville; J. W. Robertson, Livermore.

Medical and Surgical Diseases of Children—E. S. Meade, San José, Chairman; Elizabeth Gallimore, San José; John Fife, Red Bluff; E. A. Follansbee, Los Angeles.

State Medicine and Hygiene, and Adulteration of Foods and Drugs—W. R. Cluness, San Francisco, Chairman; J. H. Stallard, San Francisco; Chester Rowell, Fresno; H. S. Orme, Los Angeles; M. M. Chipman, San José.

Gynecology—Luke Robinson, San Francisco, Chairman; Charlotte B. Brown, San Francisco; A. G. Anthony, Oakland; J. T. Stewart, Los Angeles.

Obstetrics and Puerperal Diseases—Wm. Fitch Cheney, San Francisco, Chairman; W. R. Cleaveland, Biggs; R. Beverly Cole, San Francisco; Elizabeth M. Yates, Woodland.

Histology and Microscopy—J. H. Wythe, Oakland, Chairman; Emma S. Merritt, San Francisco.

Indigenous Botany, Materia Medica, Pharmacy, and Medical Chemistry—W. P. Gibbons, Alameda, Chairman; S. B. P. Knox, Santa Barbara; R. G. Reynolds, Upper Lake; W. F. Wiard, Sacramento.

Medical Topography, Meteorology, Endemics, and Epidemics—J. H. Davisson, Los Angeles, Chairman; C. M. Fenn, San Diego; B. M. Gill, Dunsmuir; J. R. Laine, Sacramento.

Necrology—H. D. Lawhead, Woodland, Chairman; C. B. Bates, Santa Barbara; J. A. Owen, Red Bluff.

Prize Essay—W. F. McNutt, San Francisco, Chairman; W. S. Thorne, San Francisco; A. Abrams, San Francisco.

Dermatology and Venereal Diseases—R. L. Rigdon, San Francisco, Chairman; G. W. Stratton, Marysville.

Ophthalmology and Otology—H. Bert Ellis, Los Angeles, Chairman; Wm. Ellery Briggs, Sacramento; W. E. Hopkins, San Francisco; K. Pischl, San Francisco; H. I. Jones, San Francisco.

Laryngology and Rhinology—W. A. Martin, San Francisco, Chairman; J. D. Arnold, San Francisco; M. C. O'Toole, San Francisco.

Medical Jurisprudence—G. F. Shiels, San Francisco, Chairman; J. H. Bullard, Anaheim; C. B. Nichols, Sacramento; H. J. Crumpton, Sausalito; F. H. Payne, Berkeley.

Medical Education and Medical Legislation—Thos. Ross, Sacramento, Chairman; M. F. Price, Colton; R. H. Plummer, San Francisco; T. W. Huntington, Sacramento; C. N. Ellinwood, San Francisco.

Anatomy and Physiology—Geo. B. Somers, San Francisco, Chairman; R. P. Gober, Los Gatos; H. M. Pond, St. Helena.

Publication—A. P. Woodward, San Francisco, Chairman; S. R. Mather, San Francisco; H. E. Sanderson, San Francisco; Wm. Watt Kerr, San Francisco.

Executive Committee—Henry Gibbons, Jr., San Francisco, Chairman; G. W. Davis San Francisco; J. Rosenstirn, San Francisco.

Committee of Arrangements—C. C. Wadsworth, San Francisco, Chairman;

W. Watt Kerr, San Francisco; J. M. Williamson, San Francisco; George B. Somers, San Francisco; J. H. Parkinson, Sacramento, Secretary.

Special Committee on State Library—Wallace A. Briggs, G. L. Simmons, Jas. H. Parkinson, T. W. Huntington, Wm. Ellery Briggs, Sacramento.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, June 26, 1894.

The President, W. F. WIARD, M.D., in the Chair.

New Member.—FLORENCE BOTSFORD POWER, M.D., was duly elected a member of the Society.

American Medical Association.—DR. J. H. PARKINSON, for the Committee on Subscription to the Entertainment Fund of the American Medical Association, reported that the amount contributed by the Society had been considerably in excess of what had been required, and there would, accordingly, be a dividend returnable when final settlement had been made by the General Committee.

DR. D'ARCY POWER presented several specimens of pigs' and frogs' eyes preserved in formaline, for which is claimed the power of preserving animal tissues without coagulation of albumin or fibrin. The specimens were in excellent preservation. A 1 per cent. solution is used for preserving tissues, the commercial article being a 40 per cent. solution. The speaker reported having used formaline in a case of senile gangrene, in which he had obtained favorable results.

DR. G. C. SIMMONS stated that he had obtained, at the Mount Sinai Hospital, a supply of the glycerine extract of the erysipelas coccus. He had been using this in two cases of cancer, but had, as yet, failed to observe any result. He hoped to report the cases in detail at a subsequent meeting. Two solutions are employed, one of which is given in doses of five drops, internally, the other in doses of twenty drops.

DR. T. W. HUNTINGTON exhibited a "Murphy Button" which he had recently used in a case of cholecystoenterostomy. Murphy claims to have succeeded in making 8 anastomoses in 10 attempts with this button. Dr. G. F. Shiels, of San Francisco, had succeeded in one case in which he used the button. The speaker demonstrated the method of operation, in which Dr. Murphy must be given considerable credit, at least for his ingenuity. Its success in practice remains to be demonstrated by its more general employment. The case in which the button had been used was one of hepatic calculi. The gall bladder was considerably distended, and was filled with stones, one being as large as a good sized cherry. The patient died, and at the autopsy, the button seemed to have done its work well, but the walls of the gall bladder had suffered irreparable damage before the operation. The speaker also reported a case of cholecystotomy in a woman 35 years of age. The gall bladder was very much enlarged, containing about 4 ounces of fluid. The liver was about four times its natural size; patient received immediate relief from pain, recovered quickly from the operation, and is now enjoying excellent health, attending to household duties, with, however, a permanent fistula. The cause of obstruction is doubtful, but it was evident that the contents of the gall bladder would soon have become purulent.

DR. T. A. SNIDER read a paper on "Cystitis and Hypertrophy of the Prostate."

DR. T. W. HUNTINGTON said these conditions are amongst the commonest of ills. Before we had a thorough understanding of urinal fermentation these cases gave us much more trouble, but now we understand that prophylaxis is most important. Formerly, inestimable injury was inflicted by careless manipulation in the use of instruments, now the most careful attention to asepsis was important. The first point was to ascertain the cause of the disease; when this was specific, it was more troublesome to treat. Gonorrheal cystitis was very obstinate; he depended largely on topical treatment, in the form of irrigations, with a ¼ and ½ per cent. solution of creolin. If this failed, he resorted to other remedies, such as had been mentioned by the author. Two operations were now recommended for the relief of prostatic enlargement: (1) the suprapubic incision and crushing, (2) castration. The removal of both testes in old men has been said to give speedy and permanent relief. A large majority of these cases are compelled to use the catheter, the retention of urine at night being one of the first troubles resulting from the enlargement. The speaker advised his patients not to try to void the urine immediately after rising, but to first walk about the room for five or eight minutes; they can thus avoid the catheter life for a long time. The explanation of this is very simple. In the prone position congestion results; when the patient arises and walks about this congestion is relieved.

Dr. W. H. Baldwin: I have had considerable trouble with a case of concentric enlargement of the prostate gland, with hypertrophy of the bladder. The patient has suffered from these complications for a long time, having constant pain, with retention of urine, every few weeks. I have used creolin solution, at first injecting about 2 ounces, but gradually dilating the bladder, so that I can now use about 10 ounces. I have used ichthyol, by the rectum. This gave relief, and the gland has decreased in size. There was no ascertainable cause for this trouble. The patient had suffered from dribbling of the urine for 15 or 20 years before I saw the case. Of late he has not been compelled to use the catheter.

Dr. M. Gardner: There are two remedies for this condition: opium, and irrigation and absolute rest. Beer is a common cause, which opium and morphine will relieve.

Dr. D'Arcy Power: Another cause of cystitis, that has not been mentioned, is dyspepsia. When a substance is thrown into the circulation that affects the mucous membrane of the bladder, we will frequently have an inflammation as a result. Ascetate of potash and atropine, internally, are useful drugs; using borax with carbolic acid, locally. Lately, he had used boracic acid or biborate of zinc. When the urine is alkaline he used boracic acid. The speaker believed in thorough dilatation.

Dr. J. R. Laine believed that the class of cases mentioned by Dr. Baldwin should be included under the head of strangury rather than cystitis. The class of cases mentioned by Dr. Power were rather acute cystitis, or irritable bladder, than the class that had been mentioned in the paper. When once hypertrophy of the bladder and hypertrophy of the prostate had been established, the condition was a permanent one. The speaker had had under his care an old colored man who suffered from prostatic enlargement. He had had retention of urine for a long time. The urine was drawn off, and subsequently, at the autopsy, an egg-shell concretion on the walls of the bladder was shown. This had collapsed when the urine had been withdrawn. He regarded bladder trouble as among the most severe of all the cases that presented themselves for treatment.

Dr. W. A. Briggs: In ordinary cases of cystitis, without the complication of hypertrophy of the prostate, I endeavor to secure an aseptic condition of the bladder. I am dissatisfied with the use of the soft catheter, as in many cases it increases the irritation. I now wash out the bladder by gravity with a siphon syringe. The small nozzle of an ordinary syringe is introduced into the tube of the reservoir, raised 5 or 7 feet. The bladder is filled and emptied by depressing the reservoir, and this is repeated 5 or 6 times. I then leave in the bladder a considerable quantity of boracic acid solution. This maintains an aseptic condition for from 2 to 4 hours, and has also a refreshing effect. I should endeavor to overcome the contraction of the bladder by hydrostatic pressure, applied as already described. Internally, I use salol and methyl blue, which have given more or less satisfaction. Ten or fifteen grains of salol, three times daily, will frequently remove the odor of fermentation. I give the methyl blue in doses of ½ to 2 grains, and I have also injected it into the bladder, apparently with some success. Where we have obstruction, it must be removed. If this be a stricture, it must be treated by dilatation or urethrotomy. When decided hypertrophy exists, I agree with Dr. Laine, that any treatment is exceedingly unsatisfactory. Where we have residual urine, it must be drawn off with a catheter; following this, by irrigation. Strychnine may reinforce the tone of the bladder, especially when combined with the systematic use of the catheter to prevent overdistention.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, May 8, 1894.

The President, W. WATT KERR, M.D., in the Chair.

New Member.—ALBERT S. ADLER, M.D., was duly elected a member of the Society.

DR. W. F. MCNUTT read a paper on "Vaginal Hysterectomy for Cancer, with a Report of 23 Cases."

DR. J. H. BARBAT, who was present at the operation on the first case reported, said that owing to the extreme gravity of the case, he was surprised to learn that she was still alive.

DR. R. BEVERLY COLE said he recognized that certain cases may be prolonged, but taking the aggregate, he questioned whether the promise is equal to the risk. A large percentage of cases operated upon died, as a direct result of the operation. In Dr. McNutt's experience, the mortality had been 13 per cent. Another question to be considered, was whether all these cases were cancers. He knew of at least a dozen cases that had been pronounced cancer by celebrated microscopists in this country, and refusing to be operated upon, seemed to be going to sure destruction; yet they still live. Many cases are operated upon that are not cancer; in fact, there is a tendency to operate too much nowadays. The speaker had operated upon 7 cases, and they had all since died from recurrence of the disease; none dying as a result of the operation.

DR. JAS. SIMPSON said all his cases had died naturally. He had never advised operation. It was true that a tedious death, with excruciating pain and continuous suffering, is more terrible than to die under the surgeon's knife, and this may justify an attempt to relieve the condition.

DR. M. KROTOSZYNER did not regard this subject from the standpoint of Drs. Cole and Simpson. A limited number of cases can be saved by an operation, there being no recurrence for the remainder of their lives. Some say that if there is no return within 12 months, the possibility of a relapse is greatly lessened. Mammary cancer will probably not return if there is no evidence of recurrence at the end of two years. It is the physician's duty to prolong life, even though that life be a miserable one. If Dr. McNutt, in his 23 cases, prolonged the life of even one of his patients he was fully justified in operating.

DR. A. LILIENCRANTZ had operated on one case three years ago, and she was still alive. He had had cases that gave bad results, and others in which the results were good. Nine years ago he had operated for cancer; it returned in two years and he again operated, removing it, and there is as yet no evidence of recurrence. He thought the chances were at least even, and while he would not recommend an operation, preferring that the patient should make the choice, he certainly favored interference, and were he so unfortunate as to be the subject of a cancer, he would certainly have it removed at once.

DR. W. F. CHENEY said: Leopold, of Dresden, has a record of 75 cases that have been under observation from one to five years, and there has been no return in 72 of them.

DR. MCNUTT, in replying, said: There was no hereditary history in his cases, the microscope was often unnecessary for diagnosis, but as he had previously stated, he often employed it to discover the direction of extension of the disease, whether laterally or only from the cervix uteri. After adhesions had formed he regarded the prognosis as very grave.

American Medical Association.—THE PRESIDENT stated that the Committee of Arrangements of the American Medical Association had assigned Tuesday evening, June 5th, for the entertainment to be given by the County Society. He mentioned the features for which other evenings had been allotted, as well as the fact that a Lady's Committee had been appointed to give special attention to ladies accompanying members of the Association. On motion, the Society decided, in addition to its contribution to the general entertainment fund, that it would give an independent entertainment. The following committee, comprising the original members, with the addition of some new names, was then appointed: C. G. Kenyon, H. Gibbons, Jr., Jas. Simpson, W. F. McNutt, R. Beverly Cole, T. B. DeWitt, C. C. Wadsworth, A. P. Woodward, and the President.

Code of Ethics.—On motion, the President and Secretary were empowered to issue credentials to delegates to the American Medical Association. Said delegates being instructed to vote in favor of retention of the "Old Code."

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, May 29, 1894.

The President, JOHN F. MORSE, M.D., in the chair.

DR. T. C. RETHERS read a paper on "Skin Grafting According to the Method of Thiersch." [Published at p. 474.]

DR. DUDLEY TAIT: I consider all other methods of grafting inferior to that of Thiersch, and I quite agree with Dr. Rethers regarding the plan of allowing the wound to first granulate, especially in large wounds.

DR. M. HILDEBRAND: I did not hear all of this excellent paper. As to the method, I saw it used after the Franco-German war with success.

DR. K. PISCHL: I have had a good chance on several occasions to use Thiersch's method in cases of entropion and in cases of long standing blepharoadenitis where the margins of the lid lose their sharp border and become rounded and very often the lid turns inward, the cilia touch the cornea and as a result keratitis sets in. The operation of skin grafting here brings good results, and is performed as follows: The edge of the lid is cut laterally thus dividing it into two parts, the inner one containing the conjunctiva, the outer the skin and cilia; into the resulting gap, a piece of the mucous membrane of the nose or vagina is placed and secured by a stitch. I would like to ask Dr. Rethers if, as a rule, the epithelium heals very readily? I have noted that where the entire thickness of the skin in large pieces was used, there was always sloughing, but underneath there was a new formation. What is the best method for covering large surfaces?

DR. TAIT: In transplanting skin it is best not to use sutures to retain it in place, for by so doing the vitality of the graft is destroyed.

THE PRESIDENT: Thiersch's method is very good in some cases. It is best not to attempt to replace scar tissue; in that we need the whole thickness of the skin. I remember where, in an operation on the palm of a child's hand, the cicatricial tissue was dissected away, leaving exposed the tendons, a large flap of skin of the chest wall was dissected up and stitched to the edges of the wound, and the arm and hand fixed in an immovable condition across the chest. In five weeks the pedicle of skin was cut through and the hand thus released from the chest wall. The result was very fine, the skin of the palm being quite soft and pliable. In this case thin skin grafts would not have answered.

DR. PISCHL: I am very glad to hear this. In one case of mine, Thiersch's method could not be used; it was a case of burn where all four of the lids were turned out. I therefore used a piece of skin the whole thickness. This was not a complete success, though there was no more ectropion. On a lower lid the same method was used and sloughed out. I do not see how one can get any results unless stitches are used, especially in the eye lids.

DR. TAIT: The case mentioned by Dr. Morse was different from Thiersch's skin grafting, where the skin is carried to the part. In that case the part was carried to the skin and held there till firm growth had been established. I know it is the practice of the German surgeons to use stitches on movable parts.

Inflamed Hydrocele Simulating Hernia.—DR. G. C. MACDONALD reported a case occurring in his practice, as follows: Last Saturday I was called by telephone to meet two other medical gentlemen in consultation on a case of "strangulated hernia." On examination I found a tumor occupying the scrotum, there was a hydrocele extending upward into the canal, and also another at the bottom of the scrotum, the middle being constricted, like an hour glass. The patient, who was 26 years of age, gave the following history: One year ago this month he had received an injury, a blow upon the testicle, which swelled to the size of a hen's egg. There was no pain. In July or August a physician diagnosed it as a "strain" and gave him a stimulating liniment to apply. Later on, lotions of turpentine were used, vaseline applied, and a truss given him by another physician. By December the tumor had grown considerable and the truss gave pain. May 5, 1894, the patient was in considerable pain, and could walk with difficulty. On the 9th, the attending physician said that it was a strangulated hernia, and hot applications were applied. This diagnosis was confirmed by a consultant, and an operation was proposed. The patient took chloroform badly, and artificial respiration had to be kept up for 15 minutes; this made it necessary to hasten the operation. A tumor was found which involved the body of the testicle and tunica vaginalis, the latter being baggy but tight in the center. The specimen, also the truss worn by the patient, was presented to the Academy museum.

THE PRESIDENT exhibited the case reported at the previous meeting [*vide* MEDICAL TIMES, vol. viii, p. 447], upon which he had performed cholecystectomy.

DR. DUDLEY TAIT: I do not believe that it is necessary to ligate the duct and then turn in the edges, suturing after it is divided, similar to the method as formerly used in appendicitis. Simple suturing would be sufficient, and the sloughing out of the sutures carries out my theory. On examining the patient, I see the incision is rather low, but Dr. Morse says that it was directly over the tumor? I also see that it is oblique, that in my opinion is preferable to a vertical incision.

Hysterectomy, with Exhibition of Specimens.—DR. H. KREUTZMANN exhibited three uteri, and gave the histories of the cases as follows: CASE 1 was that of a woman 54 years old, who for the past 9 years has not menstruated and has been in very poor health. Last year I saw her first, and on examination diagnosed her case as fibroid; also, retroflexion of the uterus. At the time I did not feel justified in removing the uterus, and bent my energy to relieving the retroflexion. A pessary was tried, but with no success. Vaginal fixation was also tried, but failed. The patient afterward left the hospital. Later on, she came back, suffering with acute pelvic peritonitis. Afterward there remained a hardening on the left side of the pelvis, causing much pain and trouble, there being present a fibroid, an intractable retroflexion and a pelvic abscess. I decided to remove the uterus on the strength of these indications. The operation was easy; the abscess in the *cul-de-sac* contained about a tablespoonful of pus. The recovery was uninterrupted. CASE 2.—The second specimen shown was a uterus, the seat of carcinomatous infiltration of the cervix, extending above the os internum, removed from a woman 42 years of age. Patient had suffered for the past 2 years with considerable hemorrhage from the uterus, and had been curetted twice before she came under my care. On examination, the cervix was found large, thick and nodulated, and no ulceration. Diagnosis, carcinoma. A piece was excised and examined by Dr. D. W. Montgomery, who corroborated the diagnosis. During the operation there was much hemorrhage, almost constant sponging being necessary. Under the circumstances, both ligatures and clamps had to be used. One clamp opened up and another slipped, the tissues being very friable. The woman died on the third day. At the autopsy there were signs of septic peritonitis, and a loop of the intestine was found in a half gangrenous condition. This loop had by some means slipped between two of the many forceps left *in situ*. CASE 3.—A third uterus shown had been removed from a woman 45 years old, that very morning, and was the seat of a carcinoma of the body. Patient gave a brief history of having menstruated last 2 years ago, and for one year having had an almost continuous flow of blood. On entering hospital she was quite anemic. The uterus was large, with no apparent cancerous manifestations in the cervix, and there was a pinkish discharge from it. The cervix was then dilated and a thorough curettement done. The resulting granular mass was examined by Dr. Montgomery, and a diagnosis made of carcinoma of the glandular type. In the operation ligatures were used.[1]

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[1] The patient has since made a good recovery.

Dr. Dudley Tait read a paper on "Gastrostomy by Witzel's Method for Primary Cancer of the Esophagus." He said: The idea is to prevent leakage into the surrounding tissues. Whether this can be done or not in one or two sittings is the question. I think the surgeon should not urge the necessity of the operation; rather let the patient do that; but there is no donbt that it prolongs life for several months.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular meeting, June 11, 1894.

L. C. Lane, M.D., in the Chair.

Dr. W. A. Moore read a paper entitled "Muscular Atrophy Consequent upon Certain Articular Lesions" [to be published].

Dr. A. H. Taylor read a paper entitled "A Discussion of the Lines of Treatment of Pelvic Abscess" [published at p. 479.]

Dr. F. B. Carpenter objected to flushing the peritoneal cavity as a routine procedure after laparotomy for pelvic abscess on the ground that infectious material is thus easily carried to remote parts of the peritoneum, thereby greatly increasing the danger of peritonitis. Simple sponging of the abscess cavity is efficacious and is less dangerous. The iodoform gauze tampon is a safe drain. In a few hours satisfactory adhesions form protecting the peritoneum.

Dr. Emmet Rixford said the question of flushing depended somewhat on the individual case and on the virulence of the infectious agent. In those cases in which the pus is small in amount and the abscess cavity pretty well shut off from the general peritoneal cavity, especially if the infection is virulent, simple sponging is to be preferred, and the cavity drained with iodoform gauze packing. Where the peritoneum is extensively involved flushing is demanded and should be carried out most thoroughly. He referred to two cases of extensive suppurative peritonitis of appendicular origin cured by Dr. Abbé, of New York, by copious flushing and complete drainage through median and lumbar incisions.

Dr. R. W. Murphy said he had had a number of cases of pelvic abscess, and had found aspiration through the vagina to give satisfactory results.

Dr. L. C. Lane said the writer of the paper had made no reference to hematocele which often simulates pelvic abscess. In some cases there is a considerable amount of blood found and clots requiring the passage of a large instrument. In other cases the blood is infected and becomes rapidly foul, requiring immediate and free opening and flushing. In this latter proceeding he preferred to use a gentle stream such as is given from a rubber tube acting as a siphon. Again, pus will often find for itself an outlet through the vagina, or the intestine, or the groin. He mentioned a case of large pelvic abscess which had not been operated upon. The patient died of other trouble sometime afterward. In the site of the abscess all pus had disappeared, and in its place was a calcareous mass three inches in diameter.

Dr. Taylor, in replying, said that flushing when properly carried out, adds little to the danger in such cases. The peritoneum can and should be shut off with suitable sponges and the water poured in from a pitcher.

Dr. J. A. Simpson reported "A Case of a Child Crying *in Utero*" [published at p. 495].

SPECIAL CORRESPONDENCE.

PARIS.

[FROM OUR OWN CORRESPONDENT.]

The Overcrowded Paris Medical Faculty.—Provincial Faculties Deserted.—Female Medical Students.—M. Malassez, Charcot's Successor in the Academy of Medicine.—M. Raymond Succeeds Charcot in the Paris Medical Faculty.—Sterilized Milk at the Charité.—Dr. Buden's Method of Preparation and Feeding.—Deaths of Distinguished Medical Men.

The hospital reform epidemic has passed from an acute to a chronic stage. No further evident steps have been taken to effect the changes so loudly demanded; what is going on in official centers, if anything, is not whispered abroad. Professor Brouardel, Dean of the Paris Medical Faculty, is in great distress, trying to solve a problem that cannot be solved—how to find space and "subjects" for more than twice the number of students the Paris Medical Faculty can accommodate or provide bodies for. The dean tries to combat the difficulty by publishing addresses assuring the students their early years of medical study would be passed with as much advantage and more healthfully in a provincial medical faculty. The Minister of Public Instruction, in a circular addressed to the rectors of provincial universities and faculties, draws their attention to the sad, undeniable fact that the provincial medical faculties and schools are empty, whilst those of the attractive metropolis are full to overflowing. And the said rectors are, in French parlance, "invited" to do their best to play the part of Dame Fortune at the wheel, and work one of those changes she knows so well how to do—fill the provincial schools and thus relieve the Paris Medical Faculty from the terrible glut of medical students which increases year after year. The poor rectors must be severely taxed by this ministerial appeal, as even with the best will in the world, they are powerless. How can they by their individual efforts fill medical schools which fail to attract students by facilities offered for medical and scientific studies? This question of the desertion of the provincial medical faculties and the overcrowding of the Paris Medical Faculty was agitated a few years ago, and was ably treated by Dr. Louis Malassez in a pamphlet on the subject. Until distinguished professors find it worth while to be exiled into the provinces, these faculties will be deserted. To make this exile bearable to those accustomed to work in medical and scientific Paris centers, the salaries must be good, the laboratories well appointed, and the laboratory budget good. None of these desiderata exist; therefore, to the despair of Professor Brouardel and the Minister of Public Instruction, the Paris Medical Faculty is congested.

In the Capital, work and play are both easy; not only the male students crowd into the Paris Medical Faculty, but also women students. The number of women, dressers and internes, is a proof that there is a large number of lady medical students to add to the distress of Professor Brouardel, who can scarcely find standing room for his pupils of the sterner sex. Nevertheless, the women are treated with every consideration and courtesy in the French Medical Faculty and its hospitals. Some of these, who have taken their degree, are practising successfully; they excite less curiosity than formerly, and gain more sympathy. Mme. Stanislas Meumer, the talented wife of the distinguished Professor of Geology at the Museum of Natural History, has described a lady medical student of American origin in her clever novel entitled M. de Prerannes.

The Paris Academy of Medicine has, by the election of M. Malassez to replace M. Charcot among its members, shown that it can be influenced by real merit as well as by intrigue—the most frequent conqueror in medical and scientific elections. On a former occasion the same learned body accorded to M. Malassez the Lacage prize of 400 francs for his researches in tuberculosis. This honor was unsolicited and was consequently increased tenfold both for the donor and the receiver. The Academy of Medicine has shown in these two instances a perspicuity and rectitude of judgment other scientific and medical bodies would do well to imitate. M. Malassez has published several important contributions to scientific literature on red blood corpuscles, on tuberculosis, and on syphilitic lesions; on cysts of the face, on psororspermosis, on the cancer parasite, and other subjects.

M. Raymond is elected as M. Charcot's successor to the Chair of Nervous Diseases at the Paris Medical Faculty. M. Raymond's friends naturally rejoice at the election, but among the thoroughly impartial some surprise is evinced that Charcot's successor has not been chosen from among specialists in nervous diseases, more especially as there were distinguished candidates for the chair belonging to that category. On the death of Dr. Charcot, Dr. Brissaud was appointed to give the clinical lectures at the Salpetrière until a permanent successor was elected. Dr. Brissaud's excellent lectures will be continued until November.

Dr. Budin, in order to be perfectly certain that the nurslings in his wards at the Charité Hospital are provided with pure milk, thoroughly sterilized, has organized a laboratory in which, daily, a sufficient quantity is sterilized for the nourishment of the infants born in his wards and those brought to his Friday gratis consultations. The sterilization is effected in the following manner, with the aid of an apparatus, constructed by M. Gentile, which consists of a metal receiver tinned inside, a bottle holder, graduated bottles, and india-rubber automatic stoppers. The sterilizer can be big or small; the bottle holder must be in proportion, holding five, ten, or twenty-five bottles. The bottles are graduated; each line marks 25 grammes; the total quantity contained in each bottle varies from 50 to 200 grammes. The neck of the bottle is surmounted by a flat, smooth, emery-polished surface or rim. The automatic stoppers are small india-rubber dics, presenting on their lower surface a central, nail-shaped prolongation. In preparing the sterilized milk, care must be taken not to fill the bottles beyond the upper line; when thus filled, they are placed in the bottle holder, which, in turn, is placed in the sterilizer containing cold water, reaching the level of the milk, but not beyond. The lid is placed on the receptacle, and the water is gradually heated until it reaches boiling point. This heat is maintained for 40 minutes. The bottle holder, full of bottles, is then removed from the boiling water, and care must be taken during this operation neither to displace nor to touch the stoppers. As soon as the milk temperature lowers, the stoppers adhere closely to the bottles, and a depression is observed in their center, which attains its maximum when the milk is thoroughly cold. The depression results from the vacuum created by the condensed milk vapor which, during ebullition, forced out the air contained in the space intentionally left in the upper part of the bottle. The adherence of the india-rubber disk, and its central depression, proves that the vacuum exists; consequently, that the sterilization is complete. Another proof is furnished as follows: If the bottle is turned with its neck downwards, and a sharp tap given on the base of the bottle, the whole column of milk is displaced, and falls with a sharp tick to the other side of the bottle. Dr. Budin does not consider that the india-rubber bottles thus stoppered are altogether satisfactory. One reason is that emery-polished bottles are easily obtainable in cities; this is not so in country places. There is another important drawback. If bottles thus stoppered are shaken or knocked about, which is inevitable if they are removed from place to place; the disks become detached from the bottles. To remedy this, Dr. Budin has made india-rubber capsules, resembling the metal capsules used for mineral-water bottles. On each side of the upper part of the capsules is a very small aperture in order to prevent the capsule from bursting when distended by the vapor rising from the heated water. The lower part of the capsule terminates in a circular ridge which clasps tightly the neck of the bottle. These capsules can be used for any bottles. Care must be taken when the bottles are removed from the sterilizer to ascertain that they are fitting close to the bottles: the vacuum is not perfect, air slowly reënters; but, nevertheless, Dr. Budin affirms that the sterilization is more than sufficient as a safeguard for 24 hours. During intensely hot weather, milk thus sterilized has remained intact for several weeks. Sterilized milk must not be kept longer than 24 hours. Each bottle should contain only sufficient for one meal; if 50 grammes are sufficient, one holding that quantity must be chosen; if it be not finished, it must be thrown away, not reserved for another time—a fatal piece of economy, not unfrequently practised. When it is required to open a bottle, it should be first plunged into hot water, in order to warm the milk. The edge of the india-rubber disk is easily uplifted and thus removed. The milk should then be tasted, to ascertain that it is of the right temperature and flavor. A special apparatus, invented by Dr. Budin, called a "galactophore," is then placed on the bottle. A galactophore consists of two tubes, one coiled round the other. Air passes through the coiled one, milk through the perpendicular tube, and of an india-rubber cork. The tubes are passed through the cork and placed in the bottle of sterilized milk. An india-rubber nipple, steadied by a bone disk, is fitted into the upper aperture of the galactophore. It is evident that this instrument, like all others, must be kept scrupulously clean. Its extreme simplicity renders this easy.

Dr. Budin condemns the habit of diluting milk with water. Sterilized, unwatered milk is given in his service at the Charité Hospital and to the infant out-patients. Notes have been collected by Dr. Budin and Dr. Chavane, demonstrating that new-born and older infants are not sufficiently nourished with milk diluted with water, and clearly showing the value of Dr. Budin's method.

The medical profession has lost many of its members this winter by death. Dr. August Ollivier, Dr. Quinquaud, Dr. Jubel Renoy, Dr. Brown-Sequard. Dr. Quinquaud's death occurred after a short illness, likewise that of Dr. Jubel Renoy, who both swell the long list of martyrs to science. Dr. Quinquaud was an indefatigable worker. He solved the problem, how to continue laboratory research of the highest scientific merit with medical practice. He was a distinguished scientist and an able physician. His specialty was skin diseases. Overwrought and overworked, he was unable to resist an attack of influenza, which proved fatal after a few days' illness. Dr. Jubel Renoy fell a victim to typhoid fever, which, it is said, he contracted from his patients. Dr. Jubel Renoy rendered popular the treatment of typhoid fever by cold baths. Dr. Brown-Sequard, well known as a physiologist, and from his works on nervous diseases, of late years brought himself more prominently before the public by his "Sequardine." He was over 70 years of age when he died. Dr. August Ollivier, who occupied a most distinguished position in the profession, had been for several years ailing. He was 50 years of age when he died.

NEW YORK.

The Advantages of Southern California for the Consumptive.—Disease Notification Placards.—The Multitude of Doctors in Los Angeles.—Sign Oddities in St. Louis.—Medical Schools and Dispensaries.—St. Louis City Hospital.—Zander Institute.—Washington; the National Museum, Smithsonian Institute and Army Medical Museum.—Johns Hopkins' Medical School and Hospital.—The University of Pennsylvania and Wister Institute.—College of Physicians of Philadelphia.—New York Academy of Medicine, Medical School and Dispensaries.—Harvard Medical School.—Warren Museum.

En route to Europe, my first stopping place was Los Angeles. Here, as well as in the beautiful suburbs, nature has been lavish with her endowments. With interminable orange groves and luxuriant vegetation, enveloped in an ideal climate, it may be truly signalized as a Mecca for individuals seeking the advantages of good air which is constantly on tap. There is a consensus of opinion among phthisio-therapeutists that free drainage of the lungs with pure air constitutes not only the best curative, but the best preventive agent of pulmonary tuberculosis. It is not altitude, nor humidity, nor even dryness which determines these results; it is simply an atmosphere destitute of foreign admixture. The air may be equally pure in localities other than Southern California, but it is the uniformity of the climate, enabling the individual to live out of doors for the greater part of the year, that makes the climate of this section of the world so desirable. Consumptives are not so often seen as heard in Southern California; that is to say, they do not betray their presence as much by their physiognomy as they do by their cough. Clinicians have neglected to develop the diagnostic value of cough in its relation to certain anatomical conditions peculiar to phthisis, but it may be hoped that phonographic registration of coughs will soon establish something definite in this direction.

I was impressed with the large placards used by the authorities to indicate the presence of an infectious disease in the houses of some of the inhabitants. In San Francisco the placards employed are so small and so inconspicuously located that they fail to accomplish the object for which they were intended. Of course, such placards are of very little real value, and will be supplanted in the future by more certain means of isolation. If prophylactic medicine fails by the establishment of sanitary measures, or by protective inoculation to prevent the development of infectious diseases, then the dwellings of the future will be provided with an emergency abode, remote from the main dwelling, as a means of isolation.

There is no dearth of physicians in Los Angeles. You see their signs everywhere. The facades of some of the buildings are literally plastered with them. Unlike some of our San Francisco physicians, one sign is quite sufficient to indicate their whereabouts. In no city have I seen so many signs used to indicate the abode of physicians as in San Francisco. Why this sign perversion should exist, I do not know, If I were a stranger it would strike me as an evidence of disordered vision on the part of the inhabitants. At any rate, I should imagine that this sign multiplication would make polyopia rampant in our beautiful city of the west. The building of the Medical College in Los Angeles is certainly not imposing, but this deficiency is amply compensated by a well organized Faculty of conscientious physicians.

If sign multiplicity characterizes medical San Francisco, St. Louis is distinguished by sign oddity. In riding through the streets of the latter city, my furtive attention was directed to the following signs: Dr. Possinger, dosimetric physician; electricity as administered by Dr. Jones will cure all curable diseases; Dr. Amway, hygienist, etc., etc.

St. Louis is a city of medical schools and free dispensaries. I counted as many as 14 medical schools in St. Louis, and this list does not include many schools not reckoned under the caption of colleges in the directory. There is even a school of osteopathy established by a bone setter. It appears in St. Louis as if the physicians had resolved themselves into factions for aggrandizement or protection, with a medical college for their stronghold and a titulary Professor as an egis; and any physician who escaped the latter distinction was only daunted by the labor of asking for it. It would be an act of supererogation to say that this division of strength is attended with dire consequences. Competition in medical education, thus engendered, is not exempt from the odium which accompanies the competition of trade. Even by a most charitable process of ratiocination, such medical colleges are nought else but mills, but unlike those of the gods, they grind quickly. I overheard the following conversation between two men in St. Louis. Said the one, "Hello, Bill! you ain't driving a car no more?" "No," said Bill, "it's too hard work; and, besides that, I'm going to become a doctor. It's a blamed sight easier to wear a plug hat and glasses than to drive a car. Doc. (referring to a professor in a regular school) said I'd get through all right if I paid the fees." This conversation I hope will not be accepted as an apt illustration of the status of medical education in St. Louis. From the chaff, medical colleges may be selected in St. Louis which stand preëminent in the cause of medical education. No criticism could sully the reputation of some St. Louis professors, whose fame is national. The oldest medical school in St. Louis is the "Missouri Medical College," and its looks do not belie its age. Another building is in process of construction, to be completed in October of this year. Among the other medical colleges worthy of mention are Barnes' Medical College, Beaumont Medical College and The St. Louis Medical College. The latter institution has well equipped laboratories. The tendency of medical education throughout the colleges of the East is to supplant the lectures by practical laboratory instruction, an innovation which can only merit approval. The medical lecturer of to-day must not exceed his province as an expounder, nor subvert the object of our textbooks, which are sufficiently adequate to replace the antiquated didactic lecture.

The St. Louis City Hospital may be placed on a par with the City and County Hospital of San Francisco, vieing with the latter in antiquity and other undesirable conditions which conduce to make up a poor hospital. Some of the St. Louis newspapers report the transactions of the local medical societies, a custom which is certainly not worthy of imitation. If the public must be informed of matters medical, let the material be served in a delectable manner through the medium of popular treatises or lectures. A practice, worthy of imitation, in the St. Louis papers, is the publication of the cause of death under the death notices.

St. Louis has a novel institution called the "Mechanico-Therapeutic and Orthopedic Zander Institute." This institute is fitted out with Dr. Zander's running machinery for giving mechanical massage. The object claimed by the inventor, Dr. Zander, of Stockholm, is essentially this: that by means of mechanical apparatus the prescribed massage movements could be executed with perfect rythm and exact system. The plant is extensive and cost, so the attendant informed me, $30,000. There is, perhaps, no more advantage in mechanical than in manual massage, and perhaps very little in either, to the extent ordinarily advocated.

Washington possesses many things of interest to the student of medicine in the National Museum, Smithsonian Institution and the Army Medical Museum.

The National Museum has one room, devoted to the study of comparative anatomy, which is singularly attractive. As an introduction to an interesting series, is one illustrating the homologies of the bones in mammals, beginning with the skeletons of a man and a horse. The Smithsonian Institution has one of the most interesting collections for the study of pre-historic anthropology. The Army Medical Museum is replete with interest. Here you find the library of the Surgeon-General's office and the museum. The medical library contains 110,000 bound volumes and 150,000 pamphlets. As an index to this library, 16 royal octavo volumes are necessary, and its arrangement is a masterpiece. A fact not generally known is this: that books may be obtained through some reliable library and sent by express to any part of the United States of America. The museum contains cases illustrating the evolution of certain instruments, like the microscope, speculum and obstetrical forceps. Beginning with the Jansen microscope of about the year 1590, and consisting of two cylinders of sheet iron and a simple lens, the development of the instrument is carried through successive stages until the modern instrument is attained. In the museum may be seen a lancet used by John Hunter, as well as a set of surgical instruments used during the war of the Revolution by Dr. Benjamin Treadwell. The instruments are exceedingly formidable, dull and rusty. The knives approach a sickle in size and appearance; the retractor looks like a trident, while the bullet extractor resembles the tongs of a blacksmith. The specimens contained in the museum are too famous to warrant cursory description. Here may be found the most complete collection of Indian crania, over 3,000 in number, and of exceptional value for ethnological study. The pre-historic crania of the mound builders are exceptionally good. In the museum may be found an interesting skeleton illustrative of that rare affection, osteomalacia. The skeleton weighed 2 lbs. 13 ozs.; the limbs are mainly affected, and many of the bones could be cut with scissors; many of the joints are anchylosed and there is an abundance of fractures. There has been recently added to the museum, and imported from France, illustrations in wax of skin diseases. These are exceedingly valuable for purposes of instruction.

An ideal institution is the medical department of the Johns Hopkins University. Generously endowed and conducted by men of national reputation, like Osler, Welch, Kelly and others, it is a fitting monument to the memory of its founder. The Johns Hopkins Hospital is designed for cases of acute disease and cases of chronic disease are not admitted, except temporarily. At the time of writing, there are about 275 patients in the Hospital. The library of the Hospital contains about 3,000 books, and copies of all the leading domestic and foreign journals are kept on file. The Hospital is conducted on thoroughly modern methods. A clinic, largely visited by physicians, is the gynecological of Dr. Howard Kelly, Dr. Kelly has a prodigious amount of material at his disposal. He is an expert at ureteral catheterization. For this purpose he employs large urethral specula. After elevating the hips of the patient, the bladder balloons like the vagina when a Sims' speculum is used. By means of reflected light and manipulation of the urethral speculum, the ureters are readily brought into view. He is so expert in ureteral catheterization that he often dispenses with the speculum, summoning aid from the *tactus eruditis* only. Dr. Kelly is the youngest and busiest man in the faculty. Photography is employed extensively in all the clinics. All the members of the medical staff of the hospital are active workers. They have a medical society, as well as a medical historical society, and they issue a publication known as the "Bulletin of the Johns Hopkins Hospital."

The hygienic laboratory of this university is not so thoroughly equipped as is that of the University of Pennsylvania. The latter may be regarded as a model worthy of imitation. It is a university within a university. In fact, the University of Pennsylvania, covering 40 acres of ground, is more suggestive of wealth and power than any of the universities I have visited in this country. The library of the university has probably the most complete Egyptological collection in America. Most of the specimens in the medical museum have been transferred to the Wistar Institute of Anatomy, which is opposite the university. The institute, an imposing structure, was erected by General Wistar, in memory of his uncle, Dr. Caspar Wistar, a former professor of anatomy in the University of Pennsylvania, and was formally opened on the

21st of May, 1894. Dr. Greeman, the curator of the institute, is an enthusiast in his particular line of work. In the basement of the institute is a lot of machinery, especially designed for section cutting, freezing, etc.

The College of Physicians in Philadelphia is a model medical society. Its medical library contains 50,000 bound volumes and 19,000 unbound pamphlets, and is the second largest medical library in this country. About 300 Fellows belong to the college. It is the oldest medical society in the United States, having been instituted in the year 1787. On the upper floor is a very creditable medical museum. In the library may be seen the first medical book, published about the year 1470 by Valastus de Tarenta, and entitled "De Epidemia et Peste." One may also see in the library many interesting curios, among which may be mentioned a stethoscope used by Laennec; it is constructed of wood and looks like a large rectal syringe. There is also a thermometer supposed to have been used by Cullen; a lock of hair from the head of the immortal Jenner; a certificate granting the right to practise medicine in Venice by one of the Doges, and dated 1636.

The College of Physicians of Philadelphia, owing to its antiquity, surpasses the New York Academy of Medicine in every possible manner. The academy occupies a gorgeous structure on Forty-third street. Its library contains 40,000 bound volumes, and is open to the public daily. The main meeting-room of the Academy of Medicine is a marvel of architectural beauty. It is called Hosack Hall, and was erected as a memorial of Dr. Alexander Hosack.

The medical colleges and hospitals of New York city are very creditable and extensive organizations. Probably the best equipped under-graduate medical school is the College of Physicians and Surgeons. The post-graduate schools in New York city are the New York Polyclinic and the Post-Graduate Medical School. The latter has the advantage of better equipment. Connected with the Faculty of the Post-Graduate School is a corps of instructors numbering 123. Post-graduate instruction is a feature in New York city. The necessity for such instruction is evidenced by the large attendance of physicians from all over the country. The number of matriculates during the last session was 527; and the attendance since the opening of the school has been steadily on the increase. Success in practice comes only to him who labors. Advancement in the profession is only exceptionally attained by oddity in vestment, mannerism, or equipage. Homeopaths are admitted as matriculates to the post-graduate schools. This is a wise provision, and may do much toward weaning them from irrational dogmas which have retained their pristine vigor for more than 100 years unsullied by the progress of science. The dispensaries in New York city are numerous. Many of them are private enterprises, and furnish the specialist with an abundance of clinical material. Perhaps the largest dispensary is the German, conducted by a staff of New York's best physicians. The clinical material is prodigious. During the past year about 30,000 patients were treated at the clinic. The clinical material of the German dispensary is not used for purpose of instructing students. The building is a commodious one of brick, erected in 1883 by Mrs. Ottendorfer.

The Harvard Medical School in Boston is of brick and red sandstone, four stories in hight, and is practically fire-proof throughout. At this school four years is the required course of study, at the end of which time, if the candidate has obtained an average of over 75 per cent. in all the examinations of this course, the degree of Doctor of Medicine, *cum laude*, is given. The Boston School of Medicine, a homeopathic institution, likewise extends its curriculum to four years, and confers the degree of Bachelor of Medicine, or Bachelor of Surgery. The course of instruction at the Harvard Medical School is essentially practical and laboratory work is substituted for the usual didactic lectures in anatomy, histology, chemistry, and pathological anatomy. All the laboratories are thoroughly equipped, especially the laboratories for experimental pharmacology and therapeutics and the laboratory of histology and embryology. The latter is directed by Prof. Minot, whose life work is embryology. His text-book on human embryology is a classic. Prof. Minot is a living exponent of what an American can do with all the advantages of a German professor. I mean by this, that if our government encouraged scientific work to the extent practised in Germany, the outlook for America in scientific preëminence would be very favorable. The anatomical lecture-room of Harvard Medical School contains the tables once used by our poet physician Holmes in his anatomical lectures. The Warren Medical Museum in this school is the best private collection I have ever seen. In many respects it is superior to the Army Medical Museum. In the Warren Museum may be seen the skull and crowbar of the celebrated "crowbar case." This case is so celebrated that a description of it would prove superfluous. The corrosion specimens in this museum are exceptionally interesting. In the public park, adjoining Boston Common, is a monument erected to commemorate the discovery "that the inhaling of ether causes insensibility to pain, first proved to the world at the Mass. General Hospital in Boston, October, A. D. MDCCCXLVI." "The gift of Thomas Lee, a citizen of Boston, erected MDCCCLXVII." Will not some appreciative citizen erect a monument to the humble frog, persecuted by science for the benefit of the human race?

NEW YORK, June 19, 1894. • ALBERT ABRAMS, M.D.

REVIEWS AND NOTICES.

HOW TO USE THE FORCEPS; WITH AN INTRODUCTORY ACCOUNT OF THE FEMALE PELVIS AND OF THE MECHANISM OF DELIVERY. By Henry G. Landis, M.A., M.D., Professor of Obstetrics and Diseases of Women and Children in Starling Medical College. Revised and enlarged by Charles H. Bushong, M.D., Assistant Gynecologist and Pathologist to Demilt Dispensary, New York. Illustrated. New York: E. B. Treat. Price, $1.75.

This is an exact reproduction, and in no sense a revision, of the edition of 1889, with the addition of a few pages of "critical remarks" by Dr. Bushong. The work was originally, and in many respects still remains, a valuable one, but reissued, practically without change, it becomes, to say the least, an anachronism.

A CHAPTER ON CHOLERA FOR LAY READERS; HISTORY, SYMPTOMS, PREVENTION AND TREATMENT OF THE DISEASE. By Walter Vought, Ph.B., M.D., Medical Director and Physician-in-charge of the Fire Island Quarantine Station, Port of New York. Illustrated. Philadelphia: The F. A. Davis Company. pp. vii, 102.

This little book is clothed in plain language, is timely, and from its moderate size and ample range of topics is admirably adapted to the general public. Quite properly, nearly half of the pages are devoted to prevention, for this branch of the subject is practically of more importance than all the rest. Allusion is made to the experience of New York in 1892, when the disease was stamped out after actual appearance, in some unaccountable way, in the city. As it could not be traced to the cases at the quarantine station, it probably was due to some infected matters thrown overboard before arrival at quarantine, which floated ashore and were picked up. It is plainly told that the cholera germs operate only in the alimentary canal, and that they must gain access through the mouth by food or drink. Persons who can learn and will exercise due care to quarantine their mouths against these germs are safe. The simple precaution of cooking everything just before swallowing is sufficient. Those who handle suspicious articles must keep their fingers out of their mouths and handle nothing that goes into the mouth until the hands have been thoroughly cleansed. A paragraph is given to the dangers of railway water-closets, and the author justly says that the dejecta of passengers should not be permitted to fall upon the road-bed without previous disinfection. Better say they should not be allowed to drop at all. At this late day it is highly discreditable to car-builders and railway managers that this filthy and dangerous practice is tolerated. There is now no disease which has become more subject to intelligent control than cholera in the hands of skilled sanitarians, with fair coöperation on the part of those endangered. We know of no better medium of this important knowledge on the part of the public than the little book here mentioned.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held July 3, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

Maurice W. Brown, Alameda; Med. Dept. Univ. Pennsylvania, June 7,'94.
C. E. Congdon, San Francisco; Med. Dept. Univ. Louisville, Ky., March 13,'94.
Leon F. Garrigues, San Francisco; Med. Dept. Univ. City of New York, March 24,'91.
Emil T. Holthusen, San Francisco; Missouri Med. Coll., Mo , March 3,'85.
William Louis McGuire, Los Angeles; Saint Joseph Med. Coll., Mo , February 27,'85.
Henry Cowles Miller, Santa Barbara; Harvard Univ. Med. School, Mass., June 24,'91.
Charles C. Park, Santa Barbara; Bellevue Hosp. Med. Coll., N. Y., March 12,'88.
Harry Smith, Los Angeles; Coll. of Medicine, Univ. of Southern California, June 1,'94.
B. F. Springsteen, San Francisco; Univ. Med. Coll., Kansas City, Mo., March 20,'94.
William H. Ward, Los Angeles; Coll. Phys. and Surgs., Keokuk, Ia., February 10,'63.

A certificate was refused to R. C. Sapero, San Francisco.

CHAS. C. WADSWORTH, Secretary,

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from June 21 to July 21, 1894.

The journeys performed by First Lieutenant E. B. Frick, assistant surgeon, from Fort Townsend to Seattle, Wash., and return, on April 28, May 15 and 29, June 7 and 26, 1894, on public business in connection with the examination of recruits, in obedience to instructions from these headquarters dated April 5, 1892, are confirmed. Par. 2, S. O. 106, Dept. of the Columbia, July 3, 1894.

Major Benjamin F. Pope, surgeon, and First Lieutenant Charles Willcox, assistant surgeon, will report without delay to Colonel William M. Graham, fifth artillery, at the Presidio of San Francisco, Cal., for temporary duty in the field. Par. 2, S. O. 70, Dept. of the California, July 9, 1894.

Passed Assistant Surgeon W. F. Arnold, U S. Navy, is relieved from further duty with the U. S. Naval Battalion at Oakland Pier, and will proceed by boat to-morrow morning to Sacramento, Cal., and report for duty with the Battalion of U. S. Marines now serving in that city. Par. 1, S. O. 74, Dept. of California, July 13, 1894.

Lieutenant Colonel Albert Hartsuff, deputy surgeon-general, medical director of the department, will proceed hence by boat to Sacramento, Cal., and carry out the verbal instructions of the department commander. Upon completion thereof, he will return without delay to his proper station in this city. Par. 2, S O., 76, Dept. of California, July 15 1894.

Leave of absence for two months, is granted Captain Richard W. Johnson, assistant surgeon U. S. Army.

First Lieutenant Frank T. Meriwether, assistant surgeon, will be relieved from duty at Fort Logan, Col., by the commanding officer of that post, and will report for duty at San Diego Barracks, Cal.

First Lieutenant Charles Willcox, assistant surgeon, is relieved from duty at Angel Island, Cal., and ordered to the Presidio of San Francisco, Cal., for duty, relieving First Lieutenant Harlan McVay, assistant surgeon. Lieutenant McVay, on being thus relieved, is ordered to Alcatraz Island, Cal., for duty, relieving Capt. Ogden Rafferty, assistant surgeon. Capt. Rafferty, on being thus relieved, is ordered to Benicia Barracks, Cal., for duty, relieving Major Joseph B. Girard, surgeon. Major Girard, on being thus relieved, is ordered to duty at Presidio of San Francisco. Cal.

Lieutenant Colonel Johnson V. D. Middleton, deputy surgeon-general, is relieved from duty at the Presidio of San Francisco, Cal., and will report to the commanding general, department of California, for duty as medical director of that department, relieving Lieutenant Colonel Albert Hartsuff, department surgeon-general. Lieutenant Colonel Hartsuff, on being thus relieved, will report in person to the commanding general of the department of the Missouri, for duty as medical director of that department.

PROMOTIONS :

Lieutenant Colonel Joseph P. Wright, deputy surgeon-general, to be assistant surgeon-general, with the rank of colonel, May 16, 1894.

Capt. Wm. R. Hall, assistant surgeon, to be surgeon, with the rank of major, May 16, 1894.

ITEMS.

Dr. A. Huffaker has removed from San Leandro, Cal., to Brownsville, Cal.

Dr. Lorenzo Boido has removed form Antigua, Guatemala, to Santa Ana, San Salvador.

Errata on page 423, No. 7, vol. viii, lines 35 and 40, for chloroform read chlorobrom; also on page 424 line 7.

Dr. Edwin J. Boyes has removed his offices from 1068 Broadway, to the corner of 13th and Clay streets, Gas Company's Building, Oakland, Cal.

Medico-Chirurgical College of Philadelphia.—The Board of Trustees of the Medico-Chirurgical College recently elected the following gentlemen to various chairs in that institution: Dr. Isaac Ott, of Easton, Pa., Professor of Physiology; Dr. William E. Hughes, Professor of Clinical Medicine; Dr. Albert E. Roussel, Assistant Professor of Clinical and of Practice of Medicine; Dr. Charles W. Burr, Clinical Professor of Nervous Diseases; Dr. William C. Hollepeter, Clinical Professor of Diseases of Children and Pediatrics; Dr. Arthur H. Cleveland, Clinical Professor of Laryngology; Dr. Edward B. Gleason, Clinical Professor of Otology; and Dr. William Blair Stewart, Lecturer in Therapeutics.

Occidental Medical Times.

VOL. VIII. SEPTEMBER, 1894. No. 9.

THE TREATMENT OF PRURITUS AND OTHER HYPERESTHETIC CONDITIONS OF THE VULVA AND VAGINA.

By THOMAS MORE MADDEN, M.D., F.R.C.S., Ed.; Obstetric Physician and Gynecologist Mater Misericordiæ Hospital, Dublin; Examiner Conjoint Board Royal College of Surgeons and Apothecaries' Hall; Consultant National Lying-in-Hospital; Consulting Physician to the Children's Hospital, etc., etc.

Abnormal sensibility of the structures forming or adjoining the external genital orifice, although a symptom common to various diseases, in many cases assumes a distinctive character. In some of these instances this condition may occasion an intensity of discomfort, mental as well as physical, or may give rise to diagnostic and therapeutic difficulties greater than are met with in any other of the so-called minor ailments which come before us in daily gynecological practice. Believing, therefore, that this subject is well deserving of consideration, in the following observations I have grouped together under the above heading my clinical experience of the more common forms of hyperesthesia to which the vulva and vaginal passage are specially liable.

Pruritus Vulvæ.—Of the conditions thus included none come more frequently before us, or may occasion greater trouble to the patient and her medical attendant than pruritus of the pudendum. It is occasionally of graver importance than is generally recognized, as a possible indication of diabetes, uterine cancer, or of a neurotic or neurasthenic constitutional state. Nor is even purely local pruritus of the external genitalia by any means of such trivial consequence as it is sometimes regarded; being, on the contrary, a not infrequent factor in the causation both of nymphomania and of the gravest forms of hysterical or cerebro-nervous disorders.

Etiology.—The causes of vulvar pruritus must, in some instances, be sought in constitutional diseases, which are obviously beyond the scope of the present communication. In a far larger proportion of cases, however, it arises from direct local irritation, such as that resulting from the acrid secretions of the vulvo-vaginal glands, which, in the absence of cleanliness, may possibly become the seat of pathogenic microörganisms. Occasionally pruritus is traceable to serpiginous erosion, neuromata, or to subacute inflammatory diseases of the vulvo-vaginal mucous membrane, as often evinced in cases of vulvitis and vaginitis. In many patients pruritus is an apparently functional and distressing accompaniment of pregnancy; in others, again, it is consequent on the genital hyperemia that ushers in the catamenial periods or which attends the menopause.

Symptoms.—From whatever cause it may result, the pruritus in these cases commence by persistent vulvar tingling or irritation, which speedily develops into a pathognomonic burning, itching, presenting paroxysmal exacerbations, increased by warmth or motion, usually most troublesome at night, and invariably aggravated on the approach of the menstrual periods. On these occasions the local irritation frequently becomes so intense as to almost impel the patient to exemplify the old adage, *ubi dolor ibi digiti*, even when forewarned and fully aware that by so doing she inevitably increases her complaint, the eventual result of which, when not allayed by medicines, may be the development of the hysterical or other cerebro-nervous complications already alluded to.

General Treatment.—It may, perhaps, appear hardly necessary to observe that in dealing with a condition so many-sided in its etiology, the recognition, and, if possible, the removal of its exciting cause, whether constitutional or local, should be the first object of the practitioner. As this is very commonly ignored, I repeat that its practical importance is daily illustrated in cases of pruritus occurring in neurasthenic patients, or in those suffering from diabetes or carcinoma uteri, in which local measures are vainly relied upon, although no possible curative effects can be anticipated from their employment.

If, therefore, vulvar pruritus be traceable to, or is to any recognizable extent coëxistant with, a distinctly marked neurotic or hysterical temperament, our primary attention should be given to the abatement of the constitutional neurasthenia. This is attained by nerve tonics and sedatives, such as hydrobromates of iron and quinine, the bromides and hydrobromic acid in combination with valerian. If the pudendal irritation be symptomatic of uterine cancer, surgical interposition, if practicable, affords the only effectual remedy. If that should be beyond possibility, we must then only fall back on the general palliative treatment available for the relief of incurable uterine carcinoma, together with special local applications. Where vulvar irritations result from diabetes, whilst I agree with Dr. Goodell as to the value of salicylate of soda, I may add that, to be of use in such cases, it should be given in full doses and in the form of the natural salicylate, which therapeutically differs from, and is far more effective than, the foreign and the other synthetically prepared drug, which is now commonly employed under that name.

Local Treatment of Pruritus.—Even in the cases just referred to, in which pruritus vulvæ arises from constitutional causes, much may be done to palliate the symptomatic genital irritation by the use of local agents. These are of much more utility in the relief of ordinary or primarily vulvar pruritus, although even in these, constitutional treatment should generally be conjoined. For the latter purpose, the first point is to secure, as far as possible, the complete asepsis of the affected parts by frequent ablutions with hot water (120° F.), and an antiseptic soap, as coal tar, or one of the newer superfatted soaps. Of this class I have found that made by Burroughs and Wellcome, with ichthyol and lanoline, one of the most useful in these cases. Immediately after this the vulva should be freely swabbed with an efficient germicide solution, as corrosive sublimate (1:1000), boric acid)1:25), izal (1:100), or carbolic acid (1:40). In this way we secure the destruction of any pathogenic microörganisms that may have survived the previous ablution, and so bring the pruritic surface into a condition in which the local sedative application may act effectually.

Of the many topical sedatives that I have used, by far the most serviceable is methylene blue. This remedy I have been employing, not merely locally in the form of a lotion, but also internally, in grain doses in pill form, twice a day, in hospital, during the past session, and with marked benefit in a considerable number of cases. The objection to the employment of methylene blue is the inevitable staining of the parts, as well as of the linen and fingers of the patient, by whom it is applied. Even when administered internally, the rapidly blue-stained urine will soon produce a persistent discoloration of the vulvar structures. This circumstance, trivial as it may seem, I have found quite sufficient to prevent most of the patients from giving it a sufficient trial.

When methylene blue is declined by the patient on the foregoing grounds, or when, as occasionally happens, it fails or ceases to afford relief, we must fall back on some one or other of the older analgesics on which the changes must be rung until either the hyperesthesia subsides or its exciting cause be discovered and dealt with. Of these local remedies, one of the most effective is cocaine, in 5 per cent. solutions in peppermint water, or in the form of a cream made with equal parts of cocaine, chloral, menthol, and camphor, rubbed up in paroline. In some cases an excellent application is a saturated solution of boric acid, as also the long tried combination of hydrocyanic acid with borax and morphine in carbolated solutions of camphor. In many instances nothing appeared to afford such relief as either the ordinary black wash or yellow wash, both of which are more especially applicable in hospital and dispensary practice, where the cost as well as the efficacy of our remedies must be taken into consideration.

Vulvar Neuromata and Serpiginous Erosion.—Hyperesthesia of the vulvar area and vaginal orifice may, independently of pruritus, arise from the presence of highly sensitive red vascular spots and distinctly neuromatous papillæ, which are often thickly scattered throughout the vulvar mucous membrane. These commonly occasion much local irritation and acute pains on the least touch, and are amongst the frequent causes of dyspareunia as well as of pruritus. In the treatment of this condition, the surgical removal of all these neuromatous spots, as well as of the hypertrophied and inflamed papillæ was formerly regarded as essential. This view is, however, dispelled by the more correct modern doctrine that the complaint is the result of a progressive serpiginous erosion passing in succession from one part to an adjoining portion of the vulvo-vaginal mucous membrane and entirely beyond relief by excision of the affected spots. In this as in other forms of vulvar pruritus, we must be content to rely chiefly on the methods of treatment already referred to.

Vaginismus.—Although it would be impossible within the limits of this communication to discuss in detail the condition of abnormal sensibility of the vaginal orifice and adjacent parts producing such spasmodic contractions of the sphincter vaginæ as to form an impediment to marital intercourse, or dyspsareunia; yet this subject cannot be altogether ignored. In such cases the local hyperesthesia is generally evinced on any attempt at examination, being most marked about the meatus urinarius and in the vicinity of the vulvo-vaginal glands and fourchette, whence the hymen, if present, projects upward.

In my opinion the best general explanation of its symptoms may be found: (1) In the hysterical temperament of the majority of those affected. (2) In an abnormal condition ot the pudic nerve, one branch of which runs along with the artery to the clitoris, whilst the other, or superficial perineal nerve is distributed to the perineum and labia in which its terminal branches ramify.

Treatment of Vaginismus.—The two points just referred to, viz: the general association of hysteria or neurotic symptoms with vaginismus, and the abnormal condition of the pudic nerve in such cases will supply the best key to general treatment. The importance of the neurotic element in its causation and management is too commonly lost sight of in this as in many other gynecological disorders. The best results will be secured by combining that constitutional treatment, which I have elsewhere very fully described, with the no less essential local measures that are therein indicated. In the local treatment of the great majority of cases of vaginismus, the most successful results may be obtained from forcible mechanical dilatation of the vulvo-vaginal orifice and passage, so as to secure thorough nerve stretching or even to produce some slight rupture of the fibrillæ of the affected nerves.

The steps of the operation are as follows: The patient, properly prepared in the usual way for an antiseptic vaginal operation, and her bladder and rectum being evacuated, is etherized and placed in the left lateral semi-prone position. A large sized Graily Hewitt, or other bivalve speculum is then introduced and the blades expanded to the fullest extent. A tampon of antiseptic cotton, or wood wool, saturated in boracic glycerine is next passed in through the speculum so as to fill its caliber from the center to the roof of the vaginal vault. The speculum, still widely expanded, is then forcibly withdrawn so as to overcome the contractility of the vaginal walls, which in so doing are usually slightly abraded, thus at the same time thoroughly stretching or slightly rupturing the affected nerve fibers. Any hemorrhage occasioned by this procedure will be controlled by the tampon, which is to be retained in the vagina by counter pressure during the removal of the speculum, and then left *in situ* for at least 24 hours to maintain the patency of the passage. When this tampon is taken out, the vagina should be immediately irrigated with some antiseptic solution. If any trace of vaginismus, or spasmodic contraction, should subsequently remain, the same course may be repeated until the vaginal canal has regained its normal sensibility and capacity.

In some exceptional instances that curative result may not be thus readily attainable, and it may be necessary to resort to the removal of any specially hyperesthetic tissues in the vicinity of the hymen, or to some of the recent modifications of Sims' or Emmett's operations for vaginismus. These procedures will, however, in my opinion, seldom be required by gynecologists who adopt the comparatively simple and generally successful method of treatment which I have just described.

55 Merrion Square.

MUSCULAR ATROPHY CONSEQUENT ON CERTAIN ARTICULAR LESIONS.

By W. L. MOORE, M.D., Assistant, Neurological Clinic, Cooper Medical College, San Francisco.

Read before the San Francisco Medico-Chirurgical Society.

A few weeks ago a gentleman came to me for treatment, with a history which seemed of considerable importance, as it presented the symptoms of those not infrequent, yet sometimes, obscure cases of muscular atrophy consequent on certain articular lesions.

I very much regret being unable to show you the case from which my notes have been taken. The patient had promised to be here this evening for your inspection, which I feel certain would be far more instructive than any paper I could prepare on the subject. His absence is still more regretable, as my notes have been prepared with the view of delineating by a methodical examination, the characteristics of the disease.

It is a well established fact that the most diverse lesions may induce muscular atrophy. I shall, however, in this paper consider only those atrophies resulting from articular lesions, especially the traumatic form.

From its origin the case of this patient may be called surgical, since it was from a slight traumatism that the present trouble originated. But from this traumatism was produced a spinal affection, of a particular kind, which still persists, although for many months the arthritis, the immediate consequent of the traumatism, has ceased to exist.

Michael D——, æt. 50 years, native of Ireland, occupation laborer, has always been healthy and has presented nothing worthy of note in his own or antecedents' family histories. His general condition is excellent; his appearance vigorous; appetite good, and all the organic functions are well performed. A few years ago patient began to be troubled in his power of locomotion. The affection from which he now suffers consists almost exclusively in a difficulty in walking, and it is the function of the left inferior extremity, or rather of certain muscles more than that member, which are at fault.

A methodical examination showed me that when he was in a recumbent position, the left inferior extremity executes, normally, all its movements except extension of the leg and thigh; the isolated movements of the foot, the flexion and extension of the foot on the leg are free. When he wishes to extend the leg placed in semiflexion, he contracts the extensors of the leg and thigh by sliding his heel along the plane of the bed, as he helps to extend the member with his hands or with the other foot. It is then the extensors of the leg and thigh which are at fault. The patient opposes, although with less force than with the sound limb, the attempts of extension or of flexion made from the joint of the foot; he resists also quite well when you try to straighten the flexed knee or hip, but he opposes only a feeble resistance to forced flexion of leg and thigh. This paresis manifests itself when the patient gets out of bed on the right side and undertakes to walk. In order to do this he raises the left leg by aid of the right foot. He walks without a cane, but there is something strange in his mode of progression. While at each step in advance the right member bends, then extends, there is hardly any attempt at flexion or extension of the affected one; the left lower extremity, too long, as it were, performs a movement of circumduction, as if it were all of one piece. There is no pain on movement, except in forced adduction of the thigh, so that the difficulty in walking cannot in this way be explained. The joints are all perfectly free. It is, then, in the nervous system or in the muscles we must look for the cause of the motor impotence.

An attentive examination of the affected limb detects a number of important particulars. There is, first, a diminution of the entire member, which was formerly very pronounced. Mensuration gives at upper part of thigh, L. 41 cm., R. 50 cm. Above knee, L. 33 cm., R. 35 cm. Calf, L. 35 cm., R. 36 cm. Even without this it is easy to see that the left extremity is considerably diminished in size. The different groups of extensors are excavated, as it were, and the muscles of these regions are flabby, and lack their usual plumpness even at the moment of contraction. There exists, then, not only a paresis, but also a modification of the nutrition, an atrophy of the extensors. The affected extremity seems also to be colder than its fellow, but without marked change of cutaneous sensibility. To complete the description I shall give the result of electrical examination, which shows the state of nutrition of the muscles.

At the time this patient presented himself for treatment, galvanic and faradic excitation of the crural nerve at the fold of the groin gave scarcely any contraction, over the points of election; faradization with a strong current produced scarcely any reaction. You would, therefore, have expected to see galvanization provoke reaction. When the nutrition of the muscles is profoundly affected, as after experimental section of the nerves, or in infantile paralysis, when there is destruction of the motor cells, or in grave cases of facial paralysis, we have the "reaction of degeneration." Galvanic excitability is exalted at the same time there is absence or weakening of faradic excitability. In this case, however, the galvanic current, even with 50 elements, whatever might be the disposition of the poles, gave no more—indeed, scarcely as much—contraction as the strong faradic current. There was, then, a quantitative and not a qualitative modification of the reaction. We might think from this that we had a case of simple atrophy, not atrophy of degeneration.

Rumpf has studied the electrical reactions of the muscles in cases of joint affections, the results of which, confirmed by Erb, are that in these cases there is a simple diminution of the electric excitability, and never any qualitative modification. This absolutely distinguishes muscular alterations from degenerative atrophy.

Charcot says: "What is moreover remarkable, these muscles, which remain almost inert under the influence of the will, or that of electric excitation, direct or indirect, by faradic or galvanic excitation of the nerve, contract quite energetically when, on placing the patient on the stool of a static electric-machine, a spark is generated over the affected muscle." It now remains to search for the reason and the signification of these phenomena. This patient is affected with a paresis with simple atrophy, almost exclusively localized in the extensors of the leg and thigh, with profound modifications, quantitative only, of electric excitability. The localization of the disorders already suffices to guide us to a diagnosis.

We know that atrophic paralysis of the extensor muscles, or at least predominating in the extensors, is a frequent complication of different spontaneous or traumatic lesions affecting the corresponding joints. Thus, we sometimes find the glutei muscles atrophic as a sequel of the arthrites or of sprains of the hip joint and after the experimental injection of irritative substances into the joint. In these cases atrophy, which has all the features of simple atrophy, without any irritative characters, supervene very rapidly.

We meet with a similar traumatism in the history of our patient, and it is not necessary to go farther to find the cause. Charcot cites a case in which "the physicians who attended him appeared astonished at the contrast which existed between the arthritis, seemingly very slight relatively, but little painful, and the motor impotence which was so great. A silicate bandage, kept on for 3 weeks, did not improve matters, and when the retentative was removed there was the same contrast, the same surprise of the physicians, who could not understand how, coincident with a painless arthritis, such pronounced motor impotence could exist. It was not until 4 months after the injury that a treatment appropriate to the situation, viz., faradization, was employed; it was then, only, that an amendment took place, and that walking became less difficult." The same benefit followed in the present case after a few weeks' treatment, although it is of much longer standing.

The relations between these persistent pareses and a slight traumatism producing only a trifling degree of arthritis, should not surprise us, if we consult the natural history of atrophic paralyses, which may be called articular or which have an articular cause. Thus, a simple sprain, soon to all appearances well, a simple hydrarthrosis, an affection not inflammatory and not painful, and a slight arthritis, may determine the same troubles. There is no necessary relation between the intensity of the joint affection and that of the paralytic and atrophic phenomena.

As for the permanence of the deuteropathic accidents (paralysis and atrophy) after the cessation of the protopathic affection (arthritis), persistence is, to a certain extent, the rule. We have here in the history of paralysis of articular cause a fact of the greatest interest from a pathological and from a clinical point of view. Most authorities agree that the joint affection has, by the medium of the irritated articular nerves, reacted upon the spinal center, modifying the centers from which emanate the motor nerves and the nerves presiding over muscular nutrition. There exists, it is believed, in the spinal cord a relation more or less direct between the cells of origin of the articular centripetal nerves and those of the motor and trophic nerves of the extensor muscles.

This result, when it is produced, is constant; thus, always in the case of irritation of the nerves of the knee, for instance, it is upon the triceps, or at least more especially those muscles, that the atrophy falls. The irritation starting from the articular nerve may spread by diffusion to other groups of muscles than those directly acted upon, though it predominates in the extensors. A propagation of the articular inflammation by contiguity and continuity to the muscles in the neighborhood has been suggested; but the atrophy exists in the same degree throughout, and experiments show that it is a simple atrophy, without myositis. The hypothesis of atrophy by prolonged disuse is inadmissible, since the joint affection is usually so slight as to necessitate rest of but very short duration; besides, how are we to explain the almost exclusive localization of the atrophy in the extensors by this theory? We are thus reduced to a deuteropathic spinal affection, in consequence of which the paralysis and atrophy are produced. But in what consists the modification of the medullary center? It cannot be a profound change in the cells of the anterior horns, as in infantile paralysis, for there we have the reaction of degeneration, which is absent here unless the affection is so far advanced that the muscle is quite destroyed.

We must, then, have to deal with a sort of inertia or torpor of the cellular element. We may, therefore, conclude that if in a case of this kind we have recourse at the onset to appropriate treatment, we will obtain favorable results. Prof. Charcot says: "We have a dynamic spinal lesion, without profound modification, so far as we know, and we may safely insist upon the electric treatment." In this case the results already obtained are encouragement for the future. As to the kind of electricity, we may choose between franklinism, faradism, or galvanism, or we may employ each in turn, as has been done in this case, with favorable results.

997 Market street.

CYSTITIS AND HYPERTROPHY OF THE PROSTATE.

By T. A. Snider, M.D., Sacramento, Cal.

Read before the Sacramento Society for Medical Improvement.

Amongst the diseases of the urinary organs that we encounter in general practice, cystitis, or inflammation of the bladder, is one of the most common. If the patient has had a severe stricture, an enlarged prostate, a vesical calculus, or kidney trouble, sooner or later he will have a cystitis, and the symptoms of this complication will be the most prominent in his disease. In fact, we rarely meet with an "idiopathic" cystitis, the antecedent trouble being usually ascertainable.

Cystitis occurs in two very distinct forms, the acute and chronic; the former being severe and dangerous, the latter much less so. The milder form is common enough. There is reason to believe that the neck of the bladder is the part mainly affected. Many of the cases that are called cystitis are really prostatitis, or inflammation of the prostatic urethra, extending to the vesical mucous membrane. Anatomically the connection is such that we cannot make a distinction, and we are accustomed to speak of these cases legitimately as inflammation of the neck of the bladder.

The symptoms of this affection are frequent and painful micturition, aching pains above the pubis, extending to the loins. The urine becomes milky or cloudy from an increase of the natural mucus of the bladder. Sometimes constitutional symptoms accompany the attack.

The treatment of these cases requires mild laxatives, diuretics, demulcents, hot hip baths, and the use of the fluid extracts of buchu, triticum repans, etc. Anodynes may be required, and of these belladonna and opium are most suitable. The bromide and acetati of potash and boracic acid are also useful. In a few instances I have found oxalic acid, in ½-grain doses every 4 hours, to give speedy and permanent relief to the vesical irritability.

Prof. Guyon, of Paris, says it is now certainly an established fact that cystitis can be produced only by the intervention of a microbe. A microbe certainly plays the most prominent part in the production of cystitis, but its presence alone is not sufficient to produce the disease. The bladder will remain indifferent to the presence of the most virulent microörganisms and will continue so just as long as the mucous membrane has not undergone such modifications as to allow of these microörganisms fixing themselves in it and propagating. There will be no cystitis as long as the bladder is able to empty itself, and if there is no retention there will be resistance to infection.

The etiology, then, of cystitis is that urinary retention is the most important factor, and while there are other sources of obstruction, hypertrophy of the prostate is the most frequent, and one which affects the majority of elderly people. Out of a large number of dissections of persons from above 54 to 55, made by Sir Henry Thompson, 1 in every 3 exhibited enlarged prostate, but about one-half of them have symptoms of the complaint and about 1 in 10 require treatment for it.

This organ is composed of two lateral lobes and a median portion. The size of the enlargement has but little to do with the results in relation to micturition. I examined a patient, a few years since, whose prostate was as large as a goose egg, and yet the obstruction did not cause very serious trouble. On the other hand, a small prostate may cause severe symptoms. The part affected is the factor influencing the results. A small middle lobe will more frequently form a valve almost closing the internal orifice of the urethra, while a very large lateral increase leaves this orifice practically unobstructed.

The effect on the bladder of obstruction to urination is of a two-fold nature. On the one hand, we have dilatation, with atrophy of its muscular structure, and consequent loss of expulsive power. On the other hand, there is hypertrophy of its muscular apparatus answering the call for increased exertion. When dilatation occurs we have the condition known as atony of the bladder, the organ becoming a thin, flabby bag. When hypertrophy has been established, we have the contrary condition, which consists in irregular enlargement of the muscular bands, between which are formed diverticuli, or pouches, which under urinary pressure become thinner toward the external surface. In these the urine remains. It is in these cases that we often see the most severe forms of cystitis. The reason is the inability of the bladder to empty itself, and, as a consequence, pus and mucus and decomposing urine remain in the bladder as a source of constant and increasing trouble. The latter part of the urine voided in these cases is made up of such tough, stringy mucus and pus that it will only flow through a very large-eyed catheter.

Many persons with urinary obstruction going even to the point of retention and an overflow bladder, may escape cystitis for months, and even years, but they are always in danger of renal insufficiency.

Although the kidneys are not ordinarily the seat of sufficient pathological changes to produce death, yet this is likely to ensue under very slight provocation from suppression of urine or urinary fever and their consequences.

Of the cause of hypertrophy of the prostate, but little is known. Exposure to cold, venereal excess, etc., have been suggested, but the most plausible is that advanced by Dr. Watson, viz: that a certain number of people are prone to one variety or another of fibrous degeneration, and among the forms which this tendency assumes is prostatic hypertrophy.

In the treatment of hypertrophy of this organ, all efforts to reduce it to its original normal condition have been fruitless. Everything in the materia medica that promised any chance of success has been tried, but to no avail. This condition of the prostate resembles that which affects the tonsils which are subject to similar changes. From exposure to cold we may have temporary congestion of the surrounding tissues, and this, by the use of proper means, can be relieved, but nothing known to the profession will diminish or reduce the hypertrophy. To prevent congestion of the prostate, the patient should be instructed to avoid sitting upon cold seats, to keep the lower bowel free by gentle laxatives and enemas of hot water. Hard fecal accumulations in the rectum will greatly increase the discomfort of the patient, and should be strictly avoided.

While treatment directed to the cause of the malady is fruitless, much can be done in a palliative way toward relieving the result. The most important factor to be overcome is the presence and increasing amount of residual urine. To rid the bladder of this unnatural load and to allow it to empty itself completely, constitutes the most important feature, and the use of the catheter is the most important element in the treatment.

The precise period when we should begin the use of the catheter is altogether arbitrary, and depends upon the symptoms of the patient. If he complains of frequent calls to urinate, and if his rest is disturbed more than once or twice during the night, and if there be dribbling and involuntary flow of urine, miscalled incontinence, I always advise the use of the instrument once to three times during the 24 hours. If the amount of residual urine is not considerable, and the nocturnal calls not more than twice, and if there be no cystitis, the use of the catheter just before retiring and once during the day, will suffice. In severe cases of cystitis, however, it may become necessary to use the instrument every four or six hours.

All authorities urge the greatest caution in the use of the catheter. In the first place the greatest cleanliness must be observed and antiseptics used as often as the instrument is passed. Dr. Watson says this point cannot be too strongly urged, for in spite of the warnings and teachings scattered through all the literature on prostatic hypertrophy, against the practice of drawing off suddenly a large amount of residual urine, with a catheter which is not thoroughly clean, such remains the bad and frequent practice with many physicians. While in many cases there may be no trouble from the procedure, every year a certain number of deaths may be directly attributed to this cause.

Certain precautions are very essential to insure safety and to avoid accident of a serious nature. When a patient has a large amount of residual urine, and when the bladder is greatly distended, it is not safe to draw off all the urine immediately. A small portion should be withdrawn at intervals, sometimes replacing this with one or two ounces of a warm solution of boracic acid. While it is much easier to withdraw the urine in the standing position, fatal syncope has been known to occur, and Sir Henry Thompson recites a case in which the surgeon was prosecuted in a court of justice for manslaughter, in relation to such an occurrence. Extreme and continued distension of the bladder for 36 or 48 hours, will sometimes destroy or permanently diminish its contractile powers, and the practice of delaying the use of the catheter for the purpose of relieving the congestion by baths, opiates, etc., may result in serious mischief to the patient.

If internal treatment is required, where the catheter is systematically used and the urine not allowed to accumulate in the bladder, the the mineral and vegetable diuretics can be used with anodynes when indicated. The latter, in the form of belladonna, hyocyamus, and opium, can be more effectually used in suppository, especially when there is severe tenesmus.

In the local treatment of cystitis, I have followed the method recommended by Sir Henry Thompson, viz: the injection, after emptying the bladder, of 2 to 4 ounces of the fluid selected, at one time, letting it run out again at once, and repeating this process until the returning fluid becomes clear. This should be done in the gentlest manner possible, in imitation of nature's method of passing the urine through the ureter into the bladder. All bladder washes should be used warm, and I have often thought additional benefit accrued from using them at a higher temperature. Of the drugs used for injection, the first and one of the best is boracic acid in 4 per cent. solution. Nitrate of silver, 1 to 2 gr. to the ounce; acetate of lead; nitric acid, 1 or 2 m. to the ounce of distilled water. In cases where the urine is foul, carbolic acid, 1 to 2 drops to the ounce of distilled water is often useful.

Some authorities of high standing recommend nitrate of silver in very strong solution. Dr. H Gardner says: "The writer can vouch for the effects and safety of solutions of from 20 to 40 grains to the ounce." One ounce of the solution is injected slowly, and after a few minutes is permitted to escape. It causes severe pain for a short time only.

Seventh and K streets.

SYMPHYSIOTOMY; WITH A REPORT OF A CASE.

By George Gross, M.D., San Francisco, Cal.

Read before the California Academy of Medicine.

On the 14th of last May I had a case of labor which gives me the opportunity of bringing before you the interesting question of symphysiotomy. However interesting the historical study of this operation may be—and, indeed, there is perhaps no question in medicine of which the history is more interesting to follow than the phases through which this operation has passed—I shall only give a few data, and dwell more especially on experimental and clinical points.

Originally a French operation advocated by Sigault, in 1768, and for the first time successfully performed by him in 1777, symphysiotomy obtained much notoriety for a time, then fell into discredit under the criticism of Baudelocque and others, and was almost given up for a whole century, when the persistent efforts of the Neapolitan school and the brilliant results obtained—thanks to the new era of antisepsis, by Morisani—created an irresistible revival, especially since 1890.

In November, 1891, Spinelli, Morisani's disciple, gave a full description of the doctrine of his master, illustrating it by an experimental operation at the Baudelocque Hospital at Prof. Pinard's clinic in Paris. In January, 1892, Spinelli published the record of 24 cases operated upon in the obstetrical school of Naples, with the saving of 24 mothers and 23 children, some of the patients having twice undergone the operation. These statistics contrast most favorably with the former records of symphysiotomy, before the application of antiseptic principles. The following are the conclusions of Spinelli:

1. A fetus at term and well developed can be delivered by symphysiotomy from a deformed pelvis with a conjugata vera of at least 6.5 cm., that is a pelvis, which, in the opinion ot the accoucheurs of all countries, would be intractable to anything but embryotomy or cesarian section.
2. That any case of contracted pelvis can be treated by symphysio-

tomy, provided the operation be carried out with due antiseptic precautions and the foregoing limits be observed.

In a later lecture comparing embryotomy, cesarian section, and symphysiotomy, although doing justice to the good results obtained for the mother by the basiotribe, and for both mother and child by the cesarian section, in such clever hands as Leopold's, Prof. Pinard thinks a less cruel solution to the difficulty ought to be found in symphysiotomy within proper limits.

Before speaking of the indications and counter-indications for symphysiotomy, I shall mention some facts established by experiments and observations made in animals. Duncan says that in animals the modifications in the articulations of the pelvis during gestation and labor are much more marked than in women, and that in the female of the guinea pig, at the time of parturition, there takes place a considerable separation of the pubic bones; the ligaments in these small quadrupeds undergoing a distension of about 25 mm. (nearly 1 inch); once the labor is over, the pubis becomes again intimately united. Pfitzner observed a normal separation of the symphysis in the female of the hedge-hog; Kehrer noticed the same fact in mice; Breslaw in rabbits, and Barlow even claimed so in cows.

It has long been known that in women, in certain cases during and after parturition, a separation of the pubis can take place. Pinard mentions a case which illustrates this point: He had occasion to perform extraction by forceps on a woman with a contracted pelvis. While carefully guiding, with one finger only, the rotation of the head and the forceps, he suddenly heard a cracking noise. After delivery, as the child's head showed no signs of injury, he made a vaginal examination, and discovered to his dismay that the pubic arch presented a solution of continuity, admitting two fingers. Six weeks later, without the use of any appliance, the patient left the hospital, walking as well as she did before her confinement. This same woman was delivered at her next confinement at full term by natural forces without accident. Ohlschlaeger records a similar case in 1893.

Regarding experiments on the human subject, since Leroy and Camper of Sigault's time, the results have not varied much, and Morisani confirms the results given by Leroy. Sigault, who experimented less than Leroy, had found that the operation produced a separation of the pubis of 1 inch and a few lines only; but Leroy showed that the separation varied with the different subjects; that for each inch, or 27 mm. of pubic separation, the sacro-pubic lines are increased by two lines (5 mm.), so that for 2 ins., or 54 mm. of inter-pubic distance, the sacro-pubic lines will gain 5 lines, or 12 mm. for 2½ ins., or 67 mm., 18 mm. and for 3 ins. nearly 1 inch.

Leroy claimed that a separation of 2½ ins. was easily obtained; and he adds that in two cases where he operated successfully, the separation had reached 3 ins. (81 mm.).

The experiments carried out conjointly by Pinard, Farabœuf, and Varnier, show that in a contracted pelvis of a woman who died of nephritis 9 days after delivery with a conjugata vera of 10.8 cm., with separation of the pubis to the extent of 6 cm.; this pelvis of 10.8 became a pelvis of 12.4 cm., an increase in the antero-posterior diameter of 14 mm., or about ½ in. Upon inspection they found that the powerful posterior ligaments of the sacro-iliac articulation had not suffered any injury, while the thin anterior ligament was only stripped from the anterior aspect of the iliac bone, and the articulation slightly distended anteriorly. On removal of the wooden index, which stretched the pelvis, the joint resumed its normal position. The second experiment is still more interesting. On the pelvis of an old woman a separation of 3 cm. of the symphysis did not even produce any stripping of the anterior ligament of the sacro-iliac articulation. In general after a separation of 3 cm. the sacro-iliac articulation opens anteriorly, usually one joint resisting more than the other, while the stripping only occurs on the opposite side.

From the foregoing we know that by symphysiotomy we can obtain a marked increase in the capacity of the pelvis without inflicting any serious injury; that the degree of this enlargement will be sufficient in many cases of contracted pelvis, and that the results of the operation affect neither the consolidation of the pelvis, the walking powers, nor the progress of future pregnancies. Pinard's experiment on a pelvis with a 10.8 cm. conjugate transformed into a conjugate of 12.4 by a separation of the pubis of 6 cm. shows the wide range of possibilities opened by symphysiotomy, and, if we bear in mind that the fetal head, once engaged in the brim, the parietal protuberance (or the temporal in the after coming head) may project into the interpubic space, we get a virtual gain of another 6 or 8 mm., making a total of about 20 to 22 mm. (6 to 7 lines) in the antero-posterior lines, while there is an increase in the transverse and oblique diameters of between half and one quarter of the interpubic space.

The biparietal diameter of a full term fetus, being 95 mm., reducible to 90 mm.—say 3½ ins., delivery will become possible with a contraction of not less than 67 mm., or 2½ ins., and easy with one of 70 mm. The lowest limit generally adopted is a conjugata vera of 67 mm., or 2½ ins., some going as low as 65 mm. The highest limit varying between 80 and 85 mm. for the sacro-pubic diameter. A transversely contracted pelvis, a kyphotic pelvis, a pelvis with a pronounced anterior curve of the coccyx, an abnormally long symphysis, constitute even stronger indications for pubic section than the antero-posterior contracted pelvis. This also applies to cases of moderate general contraction, and lastly to cases where with a normal pelvis there is an abnormal development of the child. The following are the indications given by the most illustrious representatives of the contemporary Italian school—Novi and Morisani. These authors differentiate between women at full term and those who are not:

1. With the woman at full term: When the antero-posterior diameter measures 95 mm. (3¾ ins.), the forceps will suffice. According to Novi, when below 88 mm. (3½ ins.), you may try the forceps; if you fail, you must do symphysiotomy, for which operation he goes as low as 54 mm., or 2⅛ ins: Morisani places the highest limit of symphysiotomy at the same as Novi, but with him the lowest limit ends at 67 mm., about 2½ ins.

2. With the woman not at term: Both authors agree in inducing premature labor. With a pregnant woman in the seventh or eighth month with a contracted pelvis, science and conscience ought to make you give the preference to premature labor; when the conjugata vera is less than 67 mm., or 2½ ins., Morisani stands by the cesarian section. When the child is dead, of course craniotomy is preferable.

It has, however, been established by good authorities that symphysiotomy is the better procedure, when in a breech presentation the head is stopped at the brim, whether the fetus be alive or dead. This brings me to the case I had to deal with. The woman, a secundipara, 30 years old, of rather small build, was first confined about 18 months ago; the presentation then was also a breech, and prolapse of the cord caused the early death of the fetus, which was extracted, however, without injury to the mother. In the present case, after the breech had been brought down, progress became impossible, the head resting over the brim of the pelvis; the child had succumbed, and all attempts at extraction with moderate force soon proved the futility of further efforts in this direction. It became, then, almost self-evident that the easiest way to get out of the difficulty was by symphysiotomy.

With the assistance of Dr. Campbell I performed the operation, under proper antiseptic precautions with an ordinary blunt-pointed, slightly curved bistoury, with the left index as a guide behind the symphysis. I could easily get through the joint which yielded, somewhat, before section of the triangular ligament, but separated at once after its division to the extent of about an inch, so that extraction was very easy, the head following with a very slight traction. An iodoform gauze tampon readily stopped the slight venous hemorrhage;

the only difficulty met with was the rather high incision above the pubis, over the brim of which the fetal head had been so long projecting. The wound was united with silk worm gut, and a gauze tampon left behind the symphysis. A tight binder was applied until next morning, when the patient was placed in a properly padded trough.

Thanks to antiseptic principles applied during the puerperal state no complications occurred. After a week's time the woman could empty her bladder, and on the tenth day as the trough felt too hard the pelvis was steadied with sand bags. On examining the symphysis about that time, I found a perfect juxtaposition of the pubic bones. When three weeks had passed it was impossible to keep the little woman in bed any longer. I then obtained by pelvimetric measurement the following figures:

Interspinal, 21 cm. (8¼ ins.); average normal, 25 cm. (9¾ ins.).

Intercristal, 22 cm. (8¾ ins.); average normal, 28 cm. (11 ins.).

Conjugate external, 16 cm. (6⅝ ins.); average normal, 21 cm. (8¼ ins.).

Inter-trochanteric, 26.5 to 27 cm., (10½ ins.); average normal, 31 cm. ($12\frac{3}{16}$ ins.).

Conjugate diagonalis, 8 cm. (3¼ ins.); average normal, 13 cm.

Conjugate vera, 8–1.5=6.5; average normal, 11 cm. (say about 2½ ins.).

I regret being unable to give the measurements of the fetus, but it had disappeared before I had a chance to take them. In examining the condition of the symphysis I followed Dr. Dickinson's method, which consists in testing the joint for motion in an up and down direction, with the patient standing and swaying her weight from foot to foot, and also for motion backwards and forwards while walking. All I could find was slight motion in an up and down direction while the woman was swaying from foot to foot. Dickinson says that the amount of motion in the joint in his case at the end of a few weeks, was not greater than is found in many hard labors, and after many easy ones. Of course the result in my case, I must admit, was not entirely satisfactory, as it ought to have been possible, with perhaps a prompter decision to have saved the child as well; but the little woman has not given up hopes, and next time I trust I shall be more watchful, and I hope more successful.

I trust that having drawn attention to the resources to be found in symphysiotomy, its indications may be borne in mind. Strange as it may appear, in our American text-books, in Lusk's late edition of 1892, as well as in Reynolds's, you will look in vain for the word "symphysiotomy," notwithstanding the efforts made by Harris, of

Philadelphia, in his publication on this subject as early as 1883, and as late again as October, 1892. Although the first symphysiotomy performed in the United States dates back only to March, 1892, and was done in an Alabama mining town by Dr. Coggin, now of Athens, Ga., who had learned of the results of the Neapolitan school from an Italian physician he met at Heidelberg, yet, during the year 1892, the operations are already numbered by scores, and they are becoming more and more frequent in all countries; even Leopold, of cesarian fame, having adopted the method.

Accidents, however, are liable to happen, even in good hands, and future statistics will show what dangers it implies for the mothers. Permanent separation of the pubis has been observed; tears of the bladder have occurred with consecutive fistulæ, but serious accidents, such as gangrene and rupture of the bladder, may be the consequence of too persistent and unsuccessful applications of the forceps. Therefore it is recommended to ascertain beforehand the condition of the symphysis, and to make as exact measurements of the pelvis as possible.

236 Kearny street.

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A FEW POINTS ON APPENDICITIS.

By B. W. Rodgers, M.D., Oakland, Cal.

Read before the Alameda County Medical Association.

There is probably no disease in surgery which has attracted such wide attention during the past year as appendicitis. Many very able articles have been written; therefore it is with some hesitation that I attempt to present this evening a few points on this subject.

About 60 years ago Albers, of Bonn, gave a description of what is now known as appendicitis, under the name of typhlitis. The earlier observers had, therefore, mistaken the effect for the cause. It is not strange that mistakes like this occurred, for it is no easy matter to determine whether the primary seat of the inflammation is in the appendix or in the cecum, or whether the early inflammation invades the post-cecal connective tissue, causing a burrowing abscess. It is especially hard to determine this point in cases of a catarrhal nature.

Only recently have typhlitis and perityphlitis been considered as directly associated with appendicitis. They are probably always the result of appendicitis. The exceptions to this rule are extremely rare, so much so that I believe they may be ignored with perfect safety to the patient.

'Hecktoen, of Chicago, found 15 per cent. of adhesions in 280 autopsies on persons who died from other causes. Other pathologists have found from 3 to 36 per cent., showing that a very large percentage of patients do recover from appendicitis without operative interference. Treves says 80 per cent. recover spontaneously, while Talamon maintains that 90 per cent. recover without operation."

I can hardly agree with some who state that all cases of catarrhal trouble about the intestines are appendicitis, for I believe that there are many diseases in this region that are infective that do not reach the appendix.

According to Fitz's statistics over 50 per cent. of the cases occur before the twentieth year, and 60 per cent. between the sixteenth and thirtieth years. It has been met with as early as the seventh week, but it is rarely seen prior to the third year. Matterstock, in a series of 146 cases in adults, found 9 caused by foreign bodies and 63 by fecal concretions. In the remaining cases no such condition was found. It is very much more common in males than in females, about 80 per cent. occurring in the male, although the age is usually the same in both sexes.

General peritonitis is an uncommon disease, unconnected with appendicitis, especially in men and boys. Of course we find general peritonitis in the female from puerperal infection, rupture of a pyosalpinx, etc. According to the death certificates on file at the Health Office in this city, for the twelve months ending March 1st, there were 9 deaths from peritonitis, and only 1 from typhlitis. One of these cases was caused by ectopic pregnancy. Of the remaining cases, 4 were males and 4 females. It is possible that *post-mortem* examination would have revealed appendicular disease in a portion of these cases, especially amongst the males.

Fitz makes the suggestion that some cases of peritonitis which recover, in typhoid fever, are due to perforation of the appendix, Osler also states that eleven instances have come under his observation of perforation in typhoid fever and phthisis.

The appendix may be found in various positions, even on the left side. In the *Medical News* of November 25, 1893, Dr. Fowler, of Brooklyn, reports 3 cases of left-sided appendicitis, which were not recognized on account of this abnormality. Osler states that, according to his *post-mortem* notes, it is stated that the appendix has been found in close contact with the bladder; adherent to the ovary and broad ligament; in the central portion of the abdomen, close to the navel; in contact with the gall bladder; passing out at right angles and adherent to the sigmoid flexure to the left of the middle line of the abdomen; and in one case it passed with the cecum into the inguinal canal, curved upon itself, reëntered the abdomen, and was adherent to the wall of an abscess cavity just to the right of the promontory of the sacrum.

Catarrhal inflammation may induce the most characteristic features of this disease; pains in the abdomen, localized in the right iliac fossa, perhaps at first not severe enough to confine the patient in bed. This attack may pass off, to recur again in a few weeks with more severity. Possibly no tumor can be felt externally, and on rectal examination a firm, round body may or may not be felt. Temperature, 101° to 103° F.; thighs flexed; severe pain on extending the limbs; vomiting, but no fecal odor; constipation.

In perforative appendicitis there may be initial symptoms, such as nausea, constipation, and sometimes diarrhea, uneasiness and distress in the right iliac fossa. These symptoms may possibly be associated with localized peritonitis. Sudden, violent pain in the abdomen, usually in the right iliac fossa, is the most decided symptom in perforation of the appendix, and was present in 84 per cent. of the cases analyzed by Fitz. Fever, furred tongue, and vomiting may precede or accompany this pain. An initial chill is rare. Tympanites may be early and interfere considerably with the examination, or the abdomen may be hard and flat, or one side may be more prominent than the other. Diarrhea is usually more frequent in children than in adults. The appendix may hang free in the peritoneal cavity, adhesions not having formed, when the perforation at once excites a diffuse and violent peritonitis. As a rule the ulcerated appendix becomes adherent before perforation, and a localized peritonitis only results.

In many cases, not operated upon, pus may be found in the feces, just after the attack has reached the highest point, showing that the abscess has ruptured into the cecum. These cases usually recover quite rapidly. Murphy, in his recent report of 117 cases, shows that pus was present in at least 95 per cent., and advocates operation in all cases. This is probably an unsafe rule to lay down, but of course when we are reasonably certain pus is present, without doubt the proper thing to do is to operate as soon as possible, for no one can tell at what moment rupture may take place, or gangrene supervene, or whether it may rupture intra or extra-peritoneally.

In regard to the *technique* of the operation, Dawbarn, of New York, makes the following suggestions to prevent the field of operation being obstructed by the small intestines: "Turn the patient over so that he rests with the left side against the table and the field of operation uppermost. Then seize the edge of the cut in the abdominal opening with a retractor and draw it forward away from the spine. This will made a cavity, into which the small intestines will fall out of the way, while the cecum, which has a very short mesentery, cannot follow, but remains uppermost." The appendix should be tied off as close as possible to the cecum, and after removing it, apply pure carbolic acid and invert the mucous membrane of the cecal opening with two or three Lembert sutures, to prevent any infection, thoroughly irrigating the cavity or wiping with gauze sponges, providing for drainage with iodoform gauze or tubular drains, and closing each layer separately with animal sutures, except the skin, where silk may be used. With a copious antiseptic dressing and a firm binder, the toilet is complete.

With these general remarks, I would like to present to you for discussion this evening, the following propositions:

1. So-called inflammation of the small intestines is a condition almost always associated with appendicitis.
2. Recurrent cases of appendicitis can be termed proper for operation, especially when severe, and should be operated upon between the attacks, when possible.
3. Cases of a tubercular type frequently recur, and should always be operated upon.
4. In every acute case, where the condition grows worse within 24 to 36 hours, surgical interference should be prompt.
5. Appendicitis is strictly a surgical disease and should always be treated as such.
6. Cases should be seen several times a day, as obstruction may take place, and important symptoms arise in one or two hours.
7. We should never mask the symptoms by giving too much opium, as it may lead us to think the inflammation is under control, when it is really progressing rapidly.
8. Probably 90 or 95 per cent. of the diseases about the cecal region originate in the appendix.
9. All cases of acute appendicular perforation should be operated on, as well as all cases where we are reasonably certain pus is present.
10. Nearly every case of perforation of the appendix, which is accompanied by diffuse peritonitis, is fatal.
11. Pain is felt in the right iliac fossa in about one-half of the cases, and the other half feel the pain in the abdominal cavity, not localized.
12. Appendicitis in children usually progresses very rapidly and is very fatal; therefore operative interference should be prompt, as soon as a positive diagnosis can be made.

13. Perforation of the appendix may take place intra-peritoneally or extra-peritoneally. Intra-peritoneal perforation may end in local or general peritonitis. Extra-peritoneal perforation may end in a local infection, with abscess.

14. Undoubtedly, microörganisms play a very important role in the etiology of appendicitis.

15. The cardinal principle in operating is to manipulate the viscera as little as possible.

16. The danger of ventral hernia may be obviated by carefully closing each layer separately.

17. Entire closure of the wound by first intention can be effected only in cases in which the operation has been undertaken in the early stages of the attack, before suppuration is present.

18. Aspiration is considered an unsafe procedure, as we may cause the abscess to rupture, or if there is only a small amount of pus present, it may not be reached at all. An exploratory incision is far safer, and at the same time the appendix may be removed.

19. Careful search should be made for multiple abscesses. When there is an abscess, no search should be made for the appendix, unless it can be done without disturbing the peritoneal adhesions. Simply wash out the abscess and drain.

20. McBurney's point is of very little diagnostic value, as the appendix is not uniformly found in what is called a normal position. If we depend on this point, we are liable to be misled in our diagnosis.

21. Fluctuation cannot always be detected, even when an abscess of large size is present.

22. We do not always find noticeable symptoms when rupture takes place, neither can we always locate a tumor, even when an abscess of large size is present.

628 Fifteenth street.

THREE CASES OF ACUTE INFECTIOUS OSTEOMYELITIS.

By JAMES J. MCKONE, M.D., Tacoma, Wash., Surgeon to St. Joseph's Hospital; Assistant Surgeon U. S. Marine Hospital Service.

The manner in which this infection occurs is still an unsettled matter. It often follows colds or injuries. The first symptoms are severe, deep seated, gnawing pains, worse at night; these are followed by edema of the soft parts, with high fever, preceded by a severe chill. If relief is not obtained by natural or artificial means, the patient lapses into a typhoid condition; in fact, the disease is often diagnosed as typhoid fever at this time, as it is often mistaken for acute articular rheumatism in the earlier stages.

As the disease progresses, the intraosseous tension becomes so great that the vessels become occluded, and more or less extensive necrosis takes place.

Osteomyelitis, when it attacks the cortical portion, is not very severe. It produces a necrosed condition which, however, is quite amenable to treatment. If seen early, a free incision may avert the disease.

In central osteomyelitis when sinuses form, the acute symptoms subside; if the disease is extensive and no relief is afforded, the patient's health suffers greatly and the prognosis is almost hopeless. For this reason it is always best, in doubtful cases, to make one or several small openings with a gimlet, for diagnostic purposes. Even if pus is not found, the openings often give great relief. Through these holes a small probe can be introduced and a search made for necrosed bone. This cannot always be accomplished through the natural sinuses, on account of their tortuous condition.

The three following cases of the disease are the most marked that have occurred in my practice:

CASE I.—W. D. C——, aged 16; always had good health; no history of injury; family history good. His mother supposed he had "growing pains" when he first complained of pain in his right arm. When I saw patient he had a well marked swelling over the middle of the right humerus, with a temperature of 104° F. He had had a severe chill the day before; his face was anxious and he was flighty at times. The boy was placed under ether, an Esmarch bandage applied, and the thickened bone—which could be distinctly felt through the skin—cut down upon, the periosteum separated and the external surface of the bone, with the exception of two inches, was chiseled away. About two ounces of pus escaped and several large sequestra were removed. The cavity was thoroughly curetted and irrigated with a strong bichloride solution (1:500). This was then washed away with boiled water and the wound closed with sutures except at one end where a small opening was left for drainage. A dressing was then applied which consisted of a protective strip and gauze, with an abundant supply of cotton, and a bandage moderately tight to prevent secondary hemorrhage, the cotton preventing strangulation from undue pressure from the bandage. Esmarch's bandage was now removed and the limb held in a horizontal position for about one hour, to watch for secondary hemorrhage, but fortunately none appeared. This is the method commonly called Schedes'. There was no more pain and the temperature dropped to normal. The dressing was changed for the first time on the twelfth day, and the wound found united throughout. In eight days more the boy was up and has gradually obtained a useful arm. It is now nearly two years and there are no signs of recurrence.

CASE II.—T. J. M——, undertaker, 33 years of age. Family history good. Suffered from a compound comminuted fracture of the right tibia when 10 years of age. For 3 years previous to the present attack has had, at times, severe pains in the leg at night. While on a trip to Minnesota during the cold weather, he was suddenly attacked with severe pains in the affected limb, and consulted a physician, who advised an operation, to which patient would not submit. He then started for Tacoma, but the train was blockaded by snow for four days, during which time he suffered severely, being delirious at night. On arriving at Tacoma, he was taken to St. Joseph's Hospital, but for the first few days he positively refused to submit to surgical interference. He continued to suffer terribly and was finally persuaded to have an operation. With the aid of Dr. Cateman, I removed, by malet and chisel, nearly the whole of the anterior portion of the tibia, clearing out a large amount of pus and necrosed cancellous tissue. The wound was then packed with gauze. The patient did badly; he gradually lapsed into a typhoid condition, and went on from bad to worse until he was only semiconscious, remaining in that condition for nearly a week. The wound in the meantime had been treated according to strict antiseptic rules, and the patient well nourished and stimulated. After consultation with Drs. Armstrong, Beardsley, Wing and Cateman, it was decided to amputate at the knee joint. This was done, but patient never regained consciousness, and died 3 days later. During his illness he presented a well-marked septic intoxication, so common in these cases of acute infectious osteomyelitis, where there is no vent for the pent-up pus.

Case III.—Frank P——, aged 17 years, when first seen was found to be suffering from osteomyelitis of the right femur; there was no pain, which is accounted for by the existence of a tortuous sinus into the popliteal space. The bone was thickened throughout its whole extent, the knee was flexed and anchylosed. The operation was performed at St. Joseph's Hospital, Drs. Beardsley and Baldwin assisting. The bone was exposed from hip to knee on its outer surface, the whole external surface of the femur chiseled away, and a large sequestrum, about 7 inches long, and considerable debris removed. The wound was curetted, and several cloacæ which existed were treated with the actual cautery. The wound was irrigated with a strong solution of bichloride (1:500), which was afterward washed away by a milder solution to prevent systemic effects. As it was feared that the wound, on account of its large surface and numerous cloacæ, could not be made perfectly aseptic, we decided to pack with gauze for a few days. At the end of 3 days the gauze was removed and the wound mildly curetted to start a fresh oozing. This being obtained, the soft parts were drawn together and the wound dressed with gauze and cotton. At the end of ten days, with the exception of a small opening at the angle for drainage, the soft parts had completely healed. In 6 weeks from the time of the operation, the boy left the hospital, with the wound completely healed. The anchylosed condition of the limb still remained, as no attempt was made to overcome it.

In these cases of osteomyelitis of the femur, the ultimate results are not good, on account of the deep situation of the bone and the large blood vessels which are apt to be interfered with. The operation is difficult, and some small focus of infection often remains. Secondary operations are, as a rule, required.

1102 Pacific Avenue.

A SUCCESSFUL CESARIAN SECTION.

By W. S. Thorne, M.D., San Francisco, Cal., Physician to St. Mary's Hospital.

Read before the California Academy of Medicine.

Mrs. A——, aged 28, native of Italy, primipara, entered St. Mary's Hospital May 24, 1894, having been in labor since May 20th. An examination revealed a typical flat pelvis, the antero-posterior diameter of the superior strait about 1¾ inches. The sacrum was crowded down into the pelvis, the superior strait being filled by the right arm of the child. The bag of waters had ruptured two days before.

An operation was advised, and after the patient had been etherized an incision was made in the median line, extending from a point two inches above the symphysis pubis to within an inch of the ensiform cartilage. The uterus was drawn out, a rubber band placed around the cervix, and before the uterus was opened it was allowed to fall back upon a hot antiseptic towel.

The uterus was opened, the child and placenta delivered, and both the uterus and abdominal wall closed, the former with sterilized silk, the latter with a continuous catgut suture for the peritoneum and silk for the muscle and skin.

The position of the child was as follows: Occiput anterior in the right iliac fossa, the right arm filling up the superior strait. The placenta was at the normal site.

The patient was freely stimulated and hypodermics of ergotin administered. Recovery was uneventful, the temperature never having risen higher than 100° F. The child, a ten-pound boy, is alive and well.

533 Sutter street.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By Wallace A. Briggs, M.D., Sacramento, Cal., and

Henry Gibbons, Jr., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Nature and Treatment of Hemorrhage in Uterine Fibroids.—Uterine fibroids may be subperitoneal, in the broad ligaments, intraparietal or submucous. Fibroids of the broad ligaments and subperitoneal fibroids seldom cause menorrhagia. The flow is generally scanty. Intraparietal fibroids without anatomical changes of the mucosa produce sanguineous stasis of the periuterine vessels by preventing irrigation of a more or less extended part of the uterine muscular parenchyma, so that the blood flows back through the tubes in the form of menorrhagia. It is only necessary in these cases to relieve the circulatory stasis. Rest in bed, warm vaginal injections, internal and subcutaneous administration of ergot, hydrastis hamamelis are always beneficial. Electro-dynamic treatment arrests menorrhagia, and the constant current with rhythmic intervals employed by M. CHERON, the reversals without shock by DAMON, and alternating currents with 3,000 or 5,000 interruptions per second give good results. The constant current with the positive pole applied within the uterus is efficacious, even when its intensity does not exceed 50 milliamperes. APOSTOLI'S method, however, seems preferable in these cases, because it acts upon the nutrition of the tumor, as well as on the periuterine vascular system, often lessening the size of the fibroid sufficiently to prevent a recurrence of menorrhagia. When the tumor has produced anatomical changes in the uterine mucosa, more radical treatment becomes necessary. These intraparenchymatous fibroids sometimes involve the whole body of the uterus, and can hardly be distinguished from it by the microscope. The mucosa becomes degenerated, traversed by dilated indurated vessels, with friable walls opening on the surface of the uterine cavity. Metrorrhagia is almost constant, and conservative measures afford only temporary relief. In these cases the operator must choose between hysterectomy and ligature of the uterine arteries. Submucous fibroids not only cause sanguineous stasis, but they are generally accompanied by a fungous endometritis, which occasions profuse hemorrhage. Neither curettage, medical treatment, nor cauterization prove permanently beneficial, and electro-dynamic treatment is of little efficacy. Apostoli's treatment is here preferable to other methods, on account of its double action on the fibroid and the endometritis.—*Progrès Médical*, June 9, 1894.

Gynecological Gymnastics.—This treatment, invented by a Swede, TH. BRANDT, properly consists of two equally important parts—gymnastics and massage. Unfortunately, massage has hitherto usurped the most important role, and the system has thus lost a great part of its value. The best results are only obtainable by a combination of both methods, but gymnastics alone may be of great service. Practised regularly and intelligently, they often cure functional troubles, which, neglected, cause serious diseases. These movements are better seen than described, and their execution requires the greatest care and attention on the part of physician and patient. Nevertheless, this system of gymnastics can be learned by any physician who will take the trouble, while massage requires special aptitude. The patient may be allowed to practice some of the movements at home, but others require a certain degree of knowledge and experience. This method has nothing in common with ordinary exercises of skill and strength. Its aim is not to tone up the muscular system, but to produce remarkable local effects. By its different sets of movements blood may be drawn to or from the pelvic organs at will. What may be called the decongestive movements are indicated in all forms of pelvic disease, while those of opposite character are only beneficial to young girls at the formative period; to women whose reproductive organs have remained undeveloped, or to very stout women whose menses have almost disappeared. In the last class of patients, they should be combined with a severe diet. The aim of the decongestive movements is relaxation of the abdominal wall, and, there fore, the sternal extremity and the symphysis pubis should be brought near together, while the dorsal muscles, the posterior muscles of the thighs, and the femoral abductors are exercised. When the congestive movements are indicated the object is, on the contrary, great tension of the abdominal wall, and the symphysis and the xiphoid cartilage must be separated as far as possible, while every exercise tends to increase this tension. The exact physiology of this system of gynecological gymnastics is still to be determined, but it has already yielded excellent clinical results.—*Union Médicale*, May 24, 1894.

A New Treatment of Diphtheria.—DR. PIEDALUS recommends the following new method of treating diphtheria, which he has used for the last three years with the best possible results. During that time he has not lost a single case, nor once been compelled to resort to tracheotomy. The following is his formula:

Simple Syrup	gm. 1000.
Iodide of Potash	gm. 50.
Biniodide of Mercury	gm. .50.

Dose: A coffeespoonful or a dessertspoonful every two hours, according to the age of the patient.

As much as 300 grammes may be given in six or eight days to children of from four to six years. After a few hours the well known signs of iodism, coryza, salivation, etc., appear, and the dose may then be diminished, though not below the quantity which will maintain a saturated condition of the system. Two or three times a day the false membrane should be gently removed with a rounded spoon-handle, and the throat touched with a cotton tampon dipped in Van Swieten's liquid.—*Journal de Médecine de Paris*, May 27, 1894.

SURGERY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal., and

G. F. SHIELS, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

The Pathological History of Synovial Tuberculosis.—Recent examinations of about 300 specimens of diseased knee have led KÖNIG to certain conclusions which he holds to be of great importance in their bearing on the pathological history of articular tuberculosis. Pending the publication of a large work on disease of the knee, he has thought it well to make these conclusions known in a contribution to the *Centralblatt f. Chirurgie*, and also in a paper read at the International Congress at Rome. Synovial tuberculosis, he holds, whether occurring primarily in the membrane, or caused through infection from a deposit in bone, always begins with a sero-fibrinous exudation. This exudation is not to be regarded as a definite form of tuberculosis, as it may disappear without leaving any important changes in the affected joint. In most instances, however, the fibrin is deposited in successive layers on the articular cartilages and on the inner surface of the synovial membrane. The layers are thickest in those parts of the joint which are most capacious and most favorable to the deposit of fibrin. The deposited layers after a time become organized, the vessels in deposits on the synovial membrane passing directly into the fibrin, whilst those supplying the deposits on articular cartilage pass from the margin of the synovial insertion. This organization is speedily associated with the deposit in the fibrin of heaps of round and giant cells. The character of this organized deposit—whether fungoid, caseous, purulent, or fibroid—depends on the activity of the morbid process, whilst the forms it takes in different cases and in different joints are influenced by such conditions as movement of the affected joint and intra-articular pressure. So long as the disease is progressive, every organized deposit presents on its free surface a layer of unorganized fibrinous material. The new-formed tissue, and not degenerated synovial tissue, forms at first the fungoid or granulating masses of articular tuberculosis. Tubercle is primarily deposited in this new-formed tissue, and passes from this to form secondary growths of a like character in synovial membrane, cartilage, and bone. The so-called tuberculous ulceration of articular cartilage is regarded as being at first a passive process. Erosion of cartilage may be caused by a simple organized clot of blood just as readily as by tuberculous granulations. The bone is then attacked in like manner, and defects are formed, which in size and shape resemble primary osteal deposits. The present teaching with regard to the occurrence and the frequency of primary deposits in bone must, König holds, be completely revised. Primary osteal deposits occur, he states, much less frequently than is generally supposed. In a number of specimens of diseased knee, shoulder, and hip, which have been recently examined, cavities which would hitherto have been regarded as due to primary tuberculosis of bone have really, in König's opinion, been formed by the erosive action of fibrino-tuberculous and other organized new growths. In conclusion, König points out that articular cartilage and the articular extremity of a bone may also be destroyed by a granulating ostitis originating in the subcondial osseous structure. This ostitis, the results of which may be confounded with those of tuberculous disease, is not, as a rule, of tuberculous nature.—*British Medical Journal,* June 30, 1894.

An Ovarian Cyst Simulating a Strangulated Umbilical Hernia.—DR. GEORGE G. HOPKINS reports (*Boston Medical and Surgical Journal*) the following case: Flora Fader, aged 57 years, married, Scotch, was admitted to St. John's Hospital, November 27, 1893, for a strangulated umbilical hernia. I was sent for immediately, supposing it to be an intestinal hernia. I found a tumor protruding just below the umbilical opening. It was about the size of a walnut and very dark—almost black. All aseptic precautions having been taken, ether was administered. Assisted by the house staff, I proceeded to nick the strangulating band, guarding the tumor with a broad, flat director. The constriction being relieved, the tumor at once disappeared; but, to my surprise, fluid began to discharge by the opening, but there being no odor, I felt sure that my first thought was *wrong*, that is, rupture of the intestine. I enlarged the opening to 2 inches, and serous and gelatinous matter began to discharge. Exploration with the fingers discovered that a tumor occupied a large portion of the abdominal space. This tumor proved to be a multilocular gelatinous cyst of the right ovary, of an estimated weight of 25 pounds. It was entirely free from adhesions. It was necessary to extend the incision 7 inches in order to remove the tumor. The pedicle was secured with sterilized braided silk, cut short and dropped in the abdomen. The pedicle was treated with crystallized carbolic acid, after division. The toilet of the abdomen was made with great care. It was twice irrigated with Tiersch's solution. The wound was closed with deep sutures, including all the tissues. No drainage tube was used. This unpromising patient—an ambulance case—never had an unfavorable symptom. The temperature never reached 100° F. She was discharged from the hospital December 28, 1893, cured.

Harpoon Wound of the Liver.—Recovery.—DR. T. GANN, of British Honduras, reports the following case: On February 21, 1894, a strongly built man, about 28 years of age, was admitted into the Corazal District Hospital, with the following history. On the previous day he was out in his dorey spearing fish on the Rio Nuevo. The harpoon was fastened to its shaft and pointing upward. He was standing up in the boat when she gave a sudden lurch, throwing him forward on the point of the harpoon, which penetrated his abdomen. On admission, about 28 hours after the accident, he was much collapsed and complained of great pain all round the wound; about one inch of the harpoon (which afterward proved to be 7 inches in length) was seen protruding from a jagged wound immediately below the tip of the ensiform cartilage. Chloroform was administered and an incision 6 inches in length was made from the harpoon shaft through the abdominal parietes; the peritoneum was opened, and it was then found that the harpoon penetrated the right lobe of the liver, and on passing the hand backward along the under surface of the liver the point of the harpoon could be felt projecting through its posterior border. The difficulty of removing the harpoon now presented itself, as it was armed with two sharp, flattened barbs, about three-quarters of an inch long and 2 inches apart. With considerable difficulty a grooved director was passed down along the shaft of the harpoon, and upon this an incision was made forward through the liver substance with a bistoury; the harpoon was now pushed backward in order to disengage its barbs from the liver substance in which they were embedded, and was then easily removed. The peritoneum was washed out with a 1:4,000 warm perchloride of mercury solution, and nearly half a pint of dark blood-clot removed. The hemorrhage from the wound in the liver proved troublesome and was not checked for nearly half an hour. The abdominal wound was closed with five deep sutures, and a large india-rubber drainage tube was inserted along the track of the harpoon. The wound was dressed with iodoform and carbolic gauze. The drainage tube was removed on the fifth day, and, with the exception of a rise of temperature to 104° F. on the evening of the third day, the patient had no bad symptom and was discharged with the wound firmly healed on the twenty-first day after admission.—*Lancet*, June 2, 1894.

Intestinal Surgery.—BARACZ (*Centralbl. f. Chir.*) advocates the practice, under certain conditions of intestinal obstruction, of complete diversion of a portion or portions of intestine from the general tract, the ends of the diverted parts being closed by sutures. For instance, in a recorded case of successful resection of the cecum and ascending colon, the ilium was united to the transverse colon by entero-anastomosis, the terminal portion of each of the united pieces of gut being converted after the free and open end had been closed by sutures into a *cul-de-sac*. The author concludes his paper with the following statements: (1) The cecum, when diverted from the rest of the intestinal tract, produces very little, if any, fecal matter. (2) Complete diversion of a portion of intestine is not attended with extra risk, as there is no fear, as has hitherto been supposed, of rupture from stagnation of feces. (3) Total diversion of a portion of intestine is a justifiable procedure in cases of intestinal obstruction due to chronic invagination and inflammation of the walls of the intestine, or to malignant growth, when resection is contraindicated by extensive adhesions or the size of the tumor. It would be preferable to simple entero-anastomosis, as it would prevent the diseased portion of intestine being irritated by fecal matter; partial diversion, by which the author means the formation of an artificial anus, would necessitate a second operation for the removal of a distressing condition. (4) Senn's method of establishing intestinal anastomosis is the best, and is attended with the least risk of perforation. As material for the discs or plates, sliced turnip is to be preferred to decalcified bone; the vegetable disc can be more readily made and applied, and is less likely to cause profuse sloughing and perforation of the intestine.—*British Medical Journal*, July 28, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

Surgical Treatment of Egyptian Ophthalmia.—Dr. Abadie has tried the surgical treatment of granular conjunctivitis, which is so prevalent in the Orient, by the modern methods that have yielded such favorable results in the Occident. He made a trip to experiment on the disease in its native country. In regard to various methods of removing the diseased tissue he says many accomplish the desired result. One should always avoid destroying more healthy tissue than is necessary. The conjunctiva should be undermined, not destroyed. The operation should be followed by antiseptic irrigation with a 1:500 bichloride solution. In the discussion following the reading of the paper, Dr. Trousseau said he had not had such favorable results as Dr. Abadie, especially in children. Recurrences were frequent, and the conjunctiva was often not left smooth. He had noticed that of late the enthusiasts for surgical treatment were becoming less ardent in their advocacy. To make the treatment effective the surgical method must be followed by the older treatments. Dr. Galezowski said that the conjunctival fornix was the location for which granulations had a predilection, and that he had recommended for their treatment excisions of this part of the conjunctiva. Complete cure will be secured by subsequent treatment by cauterization. In replying, Dr. Abadie said that he had previously advised that surgical treatment was not suitable for children. It is true that surgical treatment is not proper in the suppurative form. He never uses jequirity, as he considers it dangerous. One cannot regulate the severity of the artificial inflammation.—*Centralblatt f. pract. Augenheikunde.*

A Case of Quinine Amaurosis.—Dr. J. H. Claiborne reports a case of total blindness from an excessive dose of quinine. The patient poured the palm of his hand nearly full of 2-grain quinine pills, which he took a short time before going to bed. He remembered nothing after going to sleep until he awoke a few days later, perfectly blind. The optic discs were pearl-white and the vessels much smaller than in health, but not so small as they subsequently became. He complained of seeing many-colored figures, that changed their hues. The sensation of red predominated. The pupils were fixed and moderately dilated. Eight days after taking the quinine he had absolutely no light perception. About 2 years later the patient, with the right eye, could see the hand 6 feet distant, while the left could only perceive light. The author draws the following conclusions: (1) Quinine in toxic doses may produce blindness. (2) The toxic dose is distinctly indeterminate. (3) The duration of the amaurosis varies largely. (4) The field of vision remains contracted. (5) Central vision usually returns to the normal. (6) There is color-blindness at first; the color percep-picture is that of restored within the central field. (7) The ophthalmoscopic tion is ultimately white atrophy. (8) Experiments on dogs show that there is atrophy of the entire optic tract. (9) The same experiments show that the cells of the cuneu are probably not affected. (10) Treatment is of no avail.—*New York Medical Journal*, June 30, 1894.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M.D., Sacramento, Cal.

The Cutaneous Absorption of Guaiacol.—Recent investigations go to show that guaiacol is readily absorbed by the skin. MM. LINOSSIER and LAMROIS have found that the process is very rapid; a quarter of an hour after the drug had been applied to the skin it was detected in the urine, and the elimination was not complete at the end of 24 hours. Analysis showed that in the urine passed during the whole of one day no less than 55 per cent. of the guaiacol applied was present. Investigation showed, moreover, that in order to obtain the maximum degree of absorption it was necessary to cover the part of the skin, over which the drug had been spread, with an impermeable dressing and some layers of cotton wool, in order to raise the temperature of the part. This method of administration seems to possess some advantages and is especially indicated as far as guaiacol and creasote are concerned, the use of which, beyond a certain extent, is limited, owing to the gastric disturbance excited when the drugs are given by the mouth.—*Medical Press and Circular.*

New Dilator for Chronic Gonorrhea.—The instrument has the shape of the usual catheter, and consists of two parallel arms which are separated by an intermediate screw. A third arm may also be added if required. A rubber cover is drawn over the instrument in use, to prevent the mucous membrane being caught between the arms. The good points of the invention are, that, entering a very small stricture, dilatation up to No. 30 Charrière is possible; it allows the application of medicines to the dilated membrane, lessens the usual irritation from the use of bougies, can be easily disinfected, is of use in gonorrheal epididymitis, and is especially of use in preparing the urethra for endoscopy.—*Therap. Monatsheft—Centralblatt f. Chirugie.*

Antipyrin as a Vesical Analgesic.—It fortunately rarely happens that irrigation of the bladder produces cramps or severe pain. M. E. VIGNERON, in three cases of this kind, (*Annal des Mal. des Organ. Genito-Urin.*), has had most favorable results from injecting a solution of antipyrin. In contrast to the use of cocaine, it can be employed for months at a time, without harm. In bladders not dilated, 10 to 20 grammes of a 4 per cent. solution of antipyrin are injected and allowed to remain ten minutes in the bladder. In dilated bladders, after irrigation, 60 to 120 grammes of a .5 to 1 per cent. solution are injected and allowed to remain.—*Centralblatt f. Chirurgie,* July 14, 1894.

Treatment of Erysipelas in Infants.—In the service of M TORDEUS, of Brussels, the treatment consists in local applications and general medication. *Local medication:* Compresses soaked in spirit of camphor with sublimate, in the following proportion: Alcohol-camphor, 1000 g.; corros. sublim. .50 g. These compresses to be kept applied to the eruption. *General medication:* Lowering the temperature by antipyretics and modifying the inflammation by antiseptics. Antifebrin and resorcin combined are given internally, the dose of antifebrin being as many centigrammes as the child is years old, and the dose of resorcin twice as much. This is repeated twice or three times daily.—*Bulletin Général de Therapeutique,* June 15, 1894.

Gonorrhea in the Female.—E. LUTHER recommends as treatment, the use of sitz baths two or three times daily; vaginal douches of weak sublimate solution, 1:5000; or a 1 per cent. sulphate of copper solution; iodine and glycerine tampons; rest; fluid diet and regulation of bowels.—*St. Petersburger med. Wochenschrift.*

Total Gangrene of the Glans-Penis—Autoplastic Operation.—QUATTRO CIOCCHI reports (*Riforma Medica*) the following case: Through a soft chancre the patient had lost nearly the whole of the skin of the penis. Ciocchi secured a lap from the front of the scrotum, sewed it in place on the penis, and after 25 days separated it from its original attachment. Perfect union took place, the wound on the scrotum healed, and the patient has a healthy penis.—*Centralblatt f. Chirurgie.*

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Pepsin Lavements in Dysentery.—Pepsin has been applied to very many of the diseases of the nosology, yet it remained for DR. SUMMERS, of Waukesha, Wis., to discover that it possesses a most satisfactory therapeutic action in dysentery. He washes out the bowel with a strong solution of pepsin (½ ounce to 6 ounces of warm water) every three hours, which act, he declares, "clears off the mucous surface effectually." He next employs a soothing injection, such as laudanum and starch, as hot as can be borne. He declares that after two or three washings and injections the patient experiences great relief, and healthy action is at once set up, when, if constitutional conditions receive due consideration, rapid healing follows.—*Therapeutic Gazette.*

Ragwort in the Treatment of Menstrual Disorders.—During a residence in the country, DR. WM. MORRELL noticed that the common ragwort was extensively gathered by the old women of the place, and on inquiry learned that there was an extensive sale for it in many parts of England. It would appear that *Senecio Jacobœa* and also *Senecio Aureus* have long been popular emmenagogues used in the treatment of dysmenorrhea. Dr. Morrell prepared a tincture, a fluid extract, and also an active principle (senecin), with which he made observations. His conclusions are that the drug succeeds admirably in those cases in which the menstrual function, having been established and performed regularly for some months or even years, is delayed or suspended as a result of cold or some similar cause. It is also of service in the amenorrhea following parturition and suckling, provided that the patient is not anemic, and nothing could be more efficacious in controlling vicarious menstruation. In general action it seems to be allied to pulsatilla.—*Medical Press and Circular*, April 25, 1894.

The Action of Extracts of Muscles, Arterial Blood and of Urine upon the Temperature.—M. H. ROGER has carried out a carefully-conducted series of experiments, rabbits and dogs being used, from which he derives the following conclusions: (1) The extracts of the muscles contain thermogenic substances, while it is impossible to say whether these substances preëxist in the tissues or originate during the manipulations which they undergo. (2) The entire arterial blood possesses a slight temperature-reducing property. (3) The entire arterial blood is sometimes thermogenic; this effect is noted when one takes it from a sick animal or exposes it to cold; in the latter case the thermogenic effect disappears when the animal is placed for 24 hours in a warm place, or when one has made a preliminary venesection. (4) Defibrinated blood, serum, and the exudates of pleurisy and of hydrocele produce elevations of temperature, sometimes preceded by a slight lowering. (5) Urine causes a lowering of temperature, secondarily an elevation; this latter effect appears to be more marked when the subject which has furnished the urine has performed muscular exercise than when he has remained in repose.—*Archives de Physiologie.—American Journal of Medical Sciences*, August, 1894.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

The Etiology and Treatment of Multiple Sclerosis.—M. MONCORVO emphasizes the relationship existing between this disease and syphilis, an observation which he has championed for many years. He contends that lues, as an etiological factor, does not usually receive the importance that it merits. He recommends the use of iodides and mercury, which yield the best results in the treatment of this affection.—*Journal de Médecine de Paris.*

The Influence of Tobacco on the Tubercle Bacillus.—There is relatively little literature showing how microörganisms react to the action of tobacco. DR. KEREZ refers to the observations of WERNICKE during the late cholera epidemic in Hamburg. The latter showed that the exportation of cigars, and, in fact, tobacco, was unattended by any danger, as the organisms of cholera rapidly succumb when brought in direct contact with tobacco. Dr. Kerez devotes the present article to certain investigations relating to the influence of tobacco on the tubercle bacilli. He directs attention to the deplorable sanitary condition of tobacco factories, and observes incidentally that the average duration of life of the laborer in tobacco factories is but 38 years. Contamination of the tobacco employed in the manufacture of cigars may be direct from the laborer, who may be a victim of tuberculosis, or through the atmosphere. The manufacture of cigars is then described in detail, through the successive stages of wetting the tobacco leaves, preparation of the filler and wrapper, moulding the cigars, and finally their preservation in forms at a temperature of 30° C. until they are sold. The writer, in describing the details of cigar-making, calls attention to the fact that, although paste is placed at the disposal of the workers, the latter, for convenience, often use their saliva for purposes of agglutination. The experimental researches of Kerez, which have been executed with every regard to detail, show practically that the microbicidal action of tobacco on the tubercle bacilli is very great and that the fresher a cigar the greater the danger of transmitting tuberculosis; and, conversely, the older a cigar the longer the action of the tobacco on tuberculous contamination, and consequently the diminished danger of inoculation.—*Centralblatt f. Bakteriologie.*

Essential Asthma.—In a clinical lecture on this subject, at the Hospital de la Charité, POTAIN defines essential asthma as a malady characterized by the occurrence of irregular or generally periodic attacks of dyspnea. He then proceeds to picture the conventional physiognomy of the disease. Death during a paroxysm is rare. Leyden made an autopsy on an individual who had died during a paroxysm, and found emphysema with bronchial dilatation; the bronchioles were congested. A number of authors attribute the pathology of asthma to a spasm of the bronchial muscles. F. Frank has provoked contraction of the bronchial muscles by irritation of the nasal fossæ of the dog. It is certain that defective oxygenation of the blood plays an important role, coupled with an abnormal excitability of the respiratory center. The diverse theories relative to the pathology of the affection have each an element of truth. The condition which always exists is an excitability of the nervous system. He believes that the nasal origin of asthma has been exaggerated. Intoxications from lead and arsenic are often concerned in the etiology. Uremia and malaria are also causes. Asthma of periodic occurrence has been controlled by quinine. Diatheses are of importance in etiology. Heredity is an unquestioned factor. The asthmatic attack can be controlled in various ways. The inhalation of fumes produced by the combustion of paper impregnated with niter, and the inhalation of ether or iodide of ethyl, will often check a paroxysm. The use of a cocaine spray to the nasal mucous membrane often has the desired effect. Narcotics and bromides are also of value. To check the bronchial congestion, cupping and faradization of the skin are recommended. The only absolutely certain treatment for inhibiting a paroxysm is the use of morphine hypodermically. The danger of inducing the morphine habit must always be considered, and morphine is only indicated as an extreme remedy, and when everything else has been given a trial. The treatment of diatheses in the interparoxysmal periods is of the utmost importance.—*Union Médicale.*

Tuberculous Infection from Scrofulous Lymph Glands.—According to VALLAND, man is rarely infected by inhalation of tuberculosis, whereas animals are usually infected through the respiratory tract. This is ascribed to the fact that the tubercle bacilli do not float in the air, as is currently supposed, but are fixed on the floor and can only be removed mechanically. Therefore infection must take place from the floor. In consequence, animals are always liable to infection by this means and human beings only when they come in direct contact with the floor, as in childhood. He then proceeds to show that tuberculous infection of the lungs in later life is secondary to tuberculosis of the lymph glands in childhood, the infectious matter being conveyed from the glands to the lungs. In corroboration of this theory, he adduced the following interesting figures: In 101 of 108 tuberculous individuals he found enlarged cervical lymph glands; in the gland, the tubercle bacilli remained quiescent for a time, and under favorable conditions they were transplanted to the lungs. He examined 2506 persons and found enlarged cervical glands in the following percentages according to age: 96 per cent. between the ages of 7 and 9, 91.6 per cent. from 10 to 12, 84 per cent. from 13 to 15, 69.7 per cent. from 16 to 18, and 68.3 per cent. from 19 to 24 years of age. According to the progressive reduction with the increase of years, infection from scrofula antedates the school period. He says further, that enlargement of the lymph glands is not an evidence of tuberculosis, as the lymph glands enlarge from other infections, to disappear in a short time. If, however, the enlargement persists, it is very suspicious, for they are found enlarged in 93 per cent. of all persons suffering from pulmonary tuberculosis. In about 68 per cent. of adults, the cervical glands contain tubercle bacilli. Aside from the usual hygienic rules, nutrition, clothing, etc., to further prevent infection, the author directs attention to the necessity of treating promptly all wounds of the face sustained in childhood. Any excoriation should be protected at once. The child should be prevented from coming in contact with the floor, and any article removed from the floor should be thoroughly cleaned before it is given to the child. He further directs attention to other precautions based on the theory of infection from the floor.—*Münchener med. Wochenschrift.*

A Review of Ninety-two Cases of Cardiac Disease.—In a review of cardiac cases treated in the out-patient clinic of the Boston City Hospital, DR. HENRY JACKSON refers to the number of patients showing symptoms suggestive of circulatory disturbances, such as dyspnea, cough, edema, or inability to work, in whom diagnosis is more or less difficult. The necessity in such cases of a careful examination of the heart, as to its size, regularity of action and force, rather than of its valvular murmurs, is emphasized. Many cases of cardiac weakness exist in which no valvular lesions are found, and no etiology can be discovered during life. The substance becomes weakened and dilatation follows. Fatty degeneration, fatty overgrowth with infiltration, degeneration of the heart muscles from coronary disease or weakness from prolonged overwork, alcoholic abuse, arterio-sclerosis or renal disease, are frequent causes of cardiac weakness, as seen in out-door clinics in general. The term "Parietal Disease" of the heart, is suggested as a convenient one for such cases. Of 92 heart cases treated, 48 were without discoverable valvular trouble. Functional disturbances were found in 5. These showed palpitation and pain in the cardiac region, and were due to excesses in tobacco or tea. Rapidity of action, without changed size or strength of the heart, was present in them. In none of the 48 cases of organic trouble, was edema marked, and in but few was albumin in the urine. In 23 cases no definite cause was assignable, but most of them were addicted to alcohol. Seven had had rheumatism. Heart enlarged in every case, with the apex outside the nipple. Irregularity of action in 13 cases. Rapidity alone in 7 cases. Feebleness of pulsation with valvular quality of first sound at the apex were the only abnormal auscultory sounds in 14 cases. Of the 39 cases of valvular trouble, 7 came for other troubles and made no complaint about the heart. Seven complained of pain and distress in the cardiac region, 15 complained of dyspnea, 7 of cough, 4 of dizziness, and 2 of edema. Only 7 had given up work on account of dyspnea. All but two were engaged in heavy work. Several, with marked valvular defects and great increase in cardiac size, were engaged in hard labor. One of them with pallor and cyanosis; heart enlarged to two inches to the left of the nipple, with loud double murmur at the base, systolic at the apex, and over tricuspid area, continued to support his family as a blacksmith. Such statistics show the ability to carry on even hard work, and for a considerable time, which a patient with marked valvular cardiac trouble may demonstrate. In 22 cases rheumatism had existed.—*Boston Medical and Surgical Journal.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

A Case of Post-epileptic Aphasia.—Dr. Mélon has reported a case which is interesting, not only as regards the etiology, but also as to the course of the disease. The patient, a soldier, gives no family history of neuropathy, but he himself presents various stigmata; he is an epileptic; unilateral facial atrophy and chromoheteropia of the iris (right blue, left gray) are present, and the pupils are very large, the right one being larger than the left. The patient has always enjoyed good health, is not syphilitic, and has lived a fairly temperate life. One day, after he had indulged freely in bad beer, he ran a distance of about a kilometer [3,280 feet], fearing that he would be late at the garrison. Immediately afterward he had an epileptic attack, followed by loss of consciousness, lasting several hours. In the course of the day he improved slowly, so that consciousness returned and he was able to walk, but a complete aphasia was found present. After several hours the patient was able to write, and the motor disturbances of speech gradually disappeared. Dr. Mélon considers the apprehension, over-exertion and intoxication as the causes of the attack, which is rather uncommon as a sequela to epileptic insults.—*Arch. méd. Belges*—*Centralblatt f. Innere Medicin.*

Idiocy and Symptomatic Epilepsy.—DRS. BOURNEVILLE and SOLLIER report the case of a boy, 6 years old, in whose family there was no history of neuropathy. The pregnancy and labor of the mother were normal. Eight hours after birth the child had the first epileptic attack, which was mild. The attacks increased gradually in frequency and intensity and were not controlled by large doses of chloral hydrate. The boy gradually failed and died 10 hours after an attack. The temperature, which during the last attack was 38.5° C., had increased to 42° immediately after death, and was 3 hours afterward still as high as 36° C. The *post-mortem* examination showed a non-atrophy of the thymus, an adhesion of the dura-mater to the skull-cap and a partial adhesion of the pia mater to the brain; also, a tumor in the region of the hypophysis. The tumor was 25 mm. broad, 30 mm. long, and 20 mm. thick. It closed the sella tursica and reached as far forward as the chiasm; posteriorly it extended to the pedunculi cerebri. The tuber cinereum and corpora mammillaria were absorbed by the tumor. The pia mater terminated at the base of the tumor, the inferior surface being uncovered by pia. The microscopical examination showed that the tumor consisted entirely of nerve tissue. A premature synostosis could not be demonstrated.—*Progrès Medical—Centralblatt f. Innere Medicin.*

A Case of Rupture of the Heart in a Melancholiac.—This case, reported by DR. VINCENT NASH, was that of a lady, 64 years of age, who had recovered from several attacks of melancholia. In a further relapse of recurrent melancholia, during which she became much depressed aud made several suicidal attempts, she had an attack of pneumonia of the lower lobe of the left lung. On the seventh day of the disease she was taken with a sudden collapse; cyanosis set in with a feeble, thread-like pulse, cold perspiration, severe dyspnea, and pain in the region of the heart. The physical signs of an affection of the mitral valve of the heart had already been discovered shortly after her admission to the asylum, prior to the beginning of the attack of pneumonia. The dyspnea became so severe that the patient could not lie down in bed; 48 hours after the beginning of the collapse death took place suddenly as the patient attempted to turn over in bed. The *post-mortem* examination revealed, besides red hepatization of the lower part of the left lung, and an affection of the mitral valve, a fatty degeneration of the heart and a rupture of the left ventricle a short distance above the apex. The pericardial sac was filled with blood-coagula. What is remarkable about the case was that she should live so long after rupture of the heart had apparently taken place.—*Journal of Mental Science—Allg. Zeitschr. der Psychiatrie.*

The Treatment of Idiots.—In a recent paper read before the Académie de Médicine, of Paris, DR. BOURNEVILLE gave the results of his researches on this subject, and his conclusions are quite unfavorable to the modern craniectomy as it has been practised during the last few years. He examined the crania of 350 idiotic or mentally deficient children who died at Bicêtre, and found that the union of the sutures of the skull does not, as a rule, take place too soon. As it is impossible during life to get an accurate idea of the condition of the sutures and the thickness of the skull, the indications for the performance of craniectomy can not be accurately formulated, and the operation will therefore sometimes be performed on skulls in which there is ample room for the brain. His examination of skulls which had been operated upon, also showed that the fenestra made can not to any great extent give more room for the brain to develop itself. The anthropologists are therefore right when they assert that the development and conformation of the cranium is secondary to that of the brain. Bourneville further states that the lesions of the brain, which are the causes of most of the forms of idiocy, are so diffuse and of such a nature as to make it hardly possible for them to be influenced by the operation spoken of. Most of the surgeons who have performed these operations agree that the improvement has, in a majority of the cases, been insignificant, doubtful, or altogether wanting, that the operation sometimes has dangerous sequelæ (paralysis, convulsions, etc.), and that it is in itself dangerous (14 deaths in 85 cases). He thinks the medico-pedagogic method, as recommended by Ed. Seguin and improved upon by himself, is the proper treatment to pursue.—*Hospitalstidende.*

FORMULÆ.

By GEO. B. SOMERS, M. D., San Francisco, Cal.

Hemorrhoids.—TUTTLE uses the following solution as an injection fluid. He never injects more than four minims at a time, even in the largest hemorrhoid.

Ac. carbolici	ʒ iss
Ac. salicylici	ʒ ss
Sod. bibor	ʒ i
Glycerin.	*ad* ℥ i

Hemoptysis.—EKLUND orders:

Sulphate of quinine	ʒ i
Ergotine	ʒ ss

For 40 pills.

S.—Three or four pills a day.

Tonsilitis.

Ol. eucalypti glob.	m xv
Spt. camphor	℥ iss
Tr. guiac.	℥ iii ss
Glycerin.	*ad.* ℥ i

S.—Ten drops on sugar, to dissolve in the mouth every hour or two.—*Bulletin of Pharmacy.*

Follicular Tonsilitis.—LEVY gives:

Olei creasoti	gtt. viii
Tinct. myrrhæ.	
Glycerini	āā ℥ ii
Aquam	*ad.* ℥ viii

S.—Use as a gargle every 2 hours.—*Medical and Surgical Reporter.*

Erysipelas.—In the local treatment of this disease, GUNTERMANN uses

Fuller's earth	℥ ii
Talcum.	
Boric acid	āā ℥ i

S.—Local use.—*Universal Medical Journal.*

Fissure of Anus.—CRIPPS uses:

Ext. conii	ʒ ii
Ol. ricini	ʒ iii
Ung. lanolin	*ad.* ℥ ii

S.—Smear a small quantity over the parts 5 minutes before a motion is expected, and again after it has taken place. By this means spasm of the sphincter is relieved.—*Medical Press.*

Tonic Pills.

Ext. cinchonæ.	
Ext. kolæ	āā gm. 75
Ext. rhei.	gm. 40
Ext. nucis vom.	gm. 8
Ferri arsen.	gm. 3
Pulv. kolæ	q.s.

Make 100 pills.

S.—Two pills at each meal.—*Bulletin de Therapeutique.*

Diphtheria—Solvent Spray.

Olei eucalypti	ʒ ii
Sodii bicarbonatis	ʒ i
Sodii bicarbonatis	ʒ ii
Glycerini	℥ ii
Aquam calcem	*ad.* Oi

S.—Apply as a spray to the membranes every half hour for from 3 to 5 minutes at a time—*College and Clinical Record.*

Painful Pharyngitis.

Morphine sulphate	gr. iv
Carbolic acid	ʒ ss
Tannic acid	ʒ ss
Glycerin.	ʒ iv
Water	ʒ iv

S.—Paint the throat 2 or 3 times daily.—*Medical Press and Circular.*

Seasickness. — ROQUETTE recommends:

Antipyrin	gr. lxxv
Cocain hydrochlor.	gr. iss
Caffein	gr. iv
Strych. sulph.	gr. $\frac{1}{30}$
Spr. vini gallici	ʒ iiss
Aq. dest.	*ad* ʒ viii

S.—A tablespoonful before embarking and others during the day, or three during the twenty-four hours.—*Medical Press and Circular.*

Rheumatic Fever.—BRYANT prescribes:

I.—Salicylate of soda	gr. viii
Acetate of potash	gr. v
Wine of colchicum	gtt. iii

S.—To be taken every 2 hours, and less frequently when the symptoms subside.

II.—Salicylate of soda	ʒ i
Tincture of opium	℥ ii
Distilled water	℥ ii

S.—Rub the affected parts energetically.—*Nouveaux Remèdes.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for July, 1894.—The deaths registered in 79 town districts of the State, during the month of July, in a population of 777,020, correspond to an annual rate of 14.76 a thousand, the total mortality having been 961. 88 deaths were due to zymotic diseases, giving an annual rate of 1.36 a thousand. Of these, 4 were due to diphtheria, 25 to cholera infantum, 28 to typhoid fever, 10 to diarrhea and dysentery, 8 to cerebro-spinal fever, 4 to whooping cough, 2 to croup, 4 to intermittent and remittent fevers, 2 to scarlet fever, 1 to measles, and 0 to small-pox. 227 deaths resulted from diseases of the respiratory organs, giving an annual rate of 3.48 a thousand. Of these, 147 were due to consumption, 45 to pneumonia, 26 to bronchitis, and 9 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.17 and .68, respectively. 88 deaths resulted from diseases of the heart, 8 from alcoholism, 4 from erysipelas, 28 from cancer, and 434 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 591,000, was 15. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Petaluma and vicinity.

METEOROLOGY.

Summary for July.—*Temperature.*—The normal temperature of the State for July is 73°, the average for July, 1894, was 75°; a departure from the normal of +0.2°. The highest monthly mean was 105°, at Palm Springs, in the desert regions of San Diego county; the lowest, 53°, at Point Reyes; the maximum temperature, 123°, at Volcano Springs, on the 25th, in the desert regions of San Diego county; the minimum 35°, at Boca, in the high mountain regions of Nevada county, on the 27th. The absolute monthly range was 88°; the greatest local monthly range was 61°, at Turlock; the least, 18°, at Eureka.

Rainfall.—The normal precipitation of the State for July is 0.05 inches; the average for July, 1894, was 0.02 inches; a departure from the normal of −0.03 inches. The greatest monthly precipitation was 1.31 inches, at Adin; the least, nothing, at a number of stations.

Wind.—The prevailing direction of wind was westerly.

Unusual Features.—The unusual meteorological feature of the month was the excessive precipitation at Salton, in the desert regions of Riverside county, there having been .23 of an inch of rain measured at that place.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for July, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean........	Highest........	Lowest........	Mean Highest........	Mean Lowest........	Mean Daily Range........	No of Days Rain Fell.....	Total Rainfall........		No. of Clear Days.....	No. of Fair Days........	No. of Cloudy Days........	Prevailing Direction.	
Auburn ....Cal.	80.5	104	62 0	-----	-----	-----	----	T.	-----	----	----	----	E.	Southern Pacific Company.
Berkeley......... "	57.7	80.0	50.0	69.0	52 0	17.0	0	0.00	83 0	17	14	0	S.	Obs. University of California.
Colfax........... "	76.6	98 0	58.0	-----	-----	-----	----	0.00	-----	----	----	----	E.	Southern Pacific Company.
Eureka.......... "	54.4	64 0	46 0	59.0	50.0	9.0	1	0 02	90.0	3	18	10	N.W.	Weather Bureau Dept. Agr.
Fresno........... "	82.7	106	56.0	100	65 0	35.0	1	T.	34.0	28	3	0	N.W.	" " "
Indio............ "	95.8	117	80.0	-----	-----	-----	----	T.	-----	----	----	----	W.	" " "
Los Angeles.... "	67.0	88 0	51.0	80.0	54.0	26.0	1	T.	76.0	13	16	2	W.	" " "
Monterey....... "	60 4	74.0	50.0	-----	-----	-----	----	0.00	-----	----	----	----	S.W.	Southern Pacific Company.
Napa........... "	69.0	92 0	54.0	80.0	57.0	23.0	1	T.	69.0	16	15	0	S.	Station Napa Insane Asylum.
Oakland......... "	59 0	82.0	50.0	71.0	52.0	19.0	1	0.01	80 0	18	12	1	W.	Chabot Observatory.
Paso Robles.... "	71.0	102	44.0	90.0	52.0	38.0	0	0.00	33.0	30	0	1	W.	Agr. Ex. Station.
Red Bluff....... "	83.0	106	61.0	99 0	68 0	31 0	1	0 02	35.0	28	3	0	N.W.	Weather Bureau Dept. Agr.
Sacramento. ... "	74.0	104	51 0	90.0	57.0	33.0	3	T.	58.0	28	2	1	S.W.	" " "
San Bernardino "	75.0	102	48.0	94 0	56.0	38.0	1	T.	54.0	26	3	1	W.	A. K. Johnson, M. D
San Diego....... "	65.0	77.0	57 0	69.0	62.0	11.0	0	0.00	82.0	24	4	3	W.	Weather Bureau Dept. Agr.
San Francisco.. "	56 4	76.0	48.0	62.0	50.0	12 0	1	T.	88 0	18	11	2	S.W.	" " "
Santa Barbara.. "	62 8	78.0	52.0	71 0	54 0	17.0	1	0.12	78.0	27	3	1	W.	Hugh D. Vail.
Santa Cruz...... "	64.0	92.0	41.0	81.0	48.0	33.0	1	T.	------	29	2	0	N.W.	W. R. Springer.
Yuma...........A. T.	91.2	113	72.0	105	78.0	27.0	1	0.36	45.0	23	7	1	S.W.	Weather Bureau Dept. Agr.

Average humidity at Paso Robles is at 2 P. M. T. means a trace of rain. Blank (----) indicates data missing.

Occidental Medical Times.

Communications are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

Sacramento: September, 1894

THE TRANSACTIONS OF THE STATE SOCIETY.

The annual volume of Transactions of the Medical Society of the State of California has just been issued by the Committee on Publication. Its appearance this year some weeks later than the previous issue is explained by the Committee as being due to causes beyond its control. The very efficient Chairman even asserts that there is no reason why the Transactions should not be ready for mailing by June 15th of any year. We do not deny the possibility that this result could be accomplished, but dilatory authors are numerous and delays more common than expedition. The discussions have been included in this issue, which adds to the value of the volume. The Committee again regrets the absence of an official stenographer, the cost of which is estimated at a very reasonable figure. As long, however, as the discussions are obtainable without expense or compliment to the Society, the propriety of expending money for an independent report, of certainly not superior character, will be questioned.

This volume, while maintaining the greatly improved character of the Transactions of the year 1893, bears evidence of still further improvement. The presswork is still poor, but the typographical arrangement is more pleasing. In the list of committees there are a number of blanks, which we understand represent appointees who were unable to qualify on account of delinquency. It seems strange that any one who has been an active member of a State Society for several years can afford to relinquish his association wherewith. In many cases this, no doubt, is more indifference than economy, but the result is none the less regrettable.

The general character of the present volume is good. There are no papers of remarkable originality or special excellence, but many are very good and of a thoroughly practical character, and all are worthy of publication. The Committee "cannot refrain from mentioning" that there were no reports from the following standing committees: Anatomy, Pathology and Pathological Anatomy, Dermatology and Venereal Diseases. This is not often excusable. When a member accepts the chairmanship of a committee, he is in duty bound to furnish a report, unless provided with good and sufficient excuse for dereliction. There is, however, some difficulty in finding chairmen for the various committees, some of which can only be filled by experts. It would, perhaps, help matters if there were some consolidation. Thus, the Committee on Anatomy might be merged with that on Surgery, and the Committee on Histology would not be missed if united with that on Pathology, with which it will always be closely related.

NOTES.

One Hundred Years in Business.

W. H. Schieffelin & Co., the well known Pharmacists, of New York, have just celebrated the 100th anniversary of their entrance into business. In commemoration of the event they have issued a neat brochure of 56 pages, with numerous photo-engravings, illustrative of their progress in earlier and in later years. The business was established in 1781, by Effingham Lawrence, but was bought in 1794 by Jacob Schieffelin, who had been his partner. During the 100 years that have since elapsed, the firm has been conducted in an unbroken line by members of the family. Perhaps one of the best evidences of the firm's stable and conservative character, is the fact that it has now in its employ ten persons whose periods of service range from thirty to forty years, and one who has been with them for forty-five years. There are a number of fac similes of checks, invoices, and accounts, dating from the last century. The fact of an unbroken and singularly successful business career for so long a period, is perhaps not surpassed by any firm that caters to the wants of the profession in this country.

Criminal Abortion.

In a recent issue of the *Medical Record*, Dr. Mary A. Dixon Jones writes most forcibly on the universal and increasing prevalence of criminal abortion. The author quotes many cases with their inevitably sad results, and dwells with special force upon the repulsive aspects of this degrading practice. The following passages are so forcible and so earnest in their truthfulness, that it would be well were they read by every woman: "There are thousands engaged in the work, reaping their rich harvests; and, at the same time, making a harvest of deaths. But the most deplorable fact is, that there are a multitude of mothers willing to assist, or, doing it continually. Who can tell the number of infant deaths? A holocaust—a great army of little children are destroyed. The loss of infant life is amazing. But, if possible, there is yet a greater evil. The woman who entertains such thoughts, who has such intentions, the mother who thus seeks the destruction of her own child, thereby perjures and blackens her own soul, and demoralizes her whole moral being. It is a prostitution of all her higher nature. To think of a mother contemplating the murder of her own child; studying to destroy the being that rests nearest to her own life, and bound to her by every tie of kindred, love, and interest. What a soul-staining! Could anything be more debasing and blunting of all the finer feelings and affections? She who in secret broods over such thoughts, who has such intentions, is making of that child and of her children murderers. The child must take on the then condition of the parents, moral and physical. It is as much a part and parcel of the parent as is the lower order of animals, where procreation is by subdivision. I could imagine that he who is guilty of signal crimes and murderous intents is born of such a woman—a woman who for days was trying to compass his murder, and was seeking opportunities to do it secretly and successfully. What reason do women give for so doing? Some say, 'It is inconvenient to have a child!' It should be their greatest happiness. Others say, 'They have too much to do, too many claims upon them, the demands of society, fashion,' etc. But this is their first duty, and should be nearest and dearest to them. Others say, 'A child is too much trouble.' Ah! an infinite source of delight should the care of her little one be to any true mother. Others again declare 'they have not the means to support it,' or that 'they want, for a while longer, to take their pleasure;' 'at some more convenient season,' say they. A burglar who takes a man's life wants the money, because work is inconvenient, he has so many demands upon him, and this may relieve him from care and trouble, and enable him, a while longer, to take his pleasure. There is more similarity between the two than we dare trace out. Women are not taught to understand these things, they are not sufficiently instructed as to the wonders of their own being, or even of the simplest laws of life and health. They do not sufficiently know the great mysteries and beauties of life, that from the moment of conception a child begins to live, that as soon as there is a combination of the two elements, it is a human being. If not then, will any one say when life begins, at what time the soul meets the body? I maintain that the destruction of this new being, even in the earlier periods of existence, is as much murder as it would be in the latter months of pregnancy, or in the earlier periods of infancy. I hold that it is as much murder to destroy a child that will be born next May as one that was born last May." In conclusion, the writer says: "I maintain that all this work is murderous, unprofessional, and degrading to the high office of a physician. A physician stands as a preserver of life, and should be the embodiment of honor and high morality."

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, August 7, 1894.

The President, W. F. WIARD, M.D., in the Chair.

DR. G. L. SIMMONS, JR., read a paper on the "Pasteur Institute, and Incidents of the International Medical Congress."

DR. W. A. BRIGGS exhibited a "suture stay" for the repair of lacerated perineum. The apparatus consists of two small steel tubes through which a wire is passed. When the suture is united it acts as a clamp maintaining the walls of the laceration in perfect apposition.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, July 10, 1894.

The President, W. WATT KERR, M.D., in the Chair.

New Members.—W. M. THORNE, M.D., and J. A. BLACK, M.D., were duly elected members of the Society.

American Medical Association.—The Committee on Entertainment of the American Medical Association, through its Chairman, DR. C. G. KENYON, presented a detailed report. A reception had been given to the Association at Pioneer Hall on June 5th, which had been an eminently successful affair. For this occasion a silver badge representing the Golden Gate and the Setting Sun, surmounted by a Golden Bear, was designed and manufactured by Geo. C. Shreve & Co., one being presented to each guest as a souvenir of the occasion. On motion, the report was received, and a vote of thanks unanimously tendered the committee for its very efficient work.

DR. H. GIBBONS, JR., of the sub-Committee on Finance of the Committee of Arrangements of the American Medical Association, reported in the matter of the Society's contribution that there would probably be a dividend of $700, payable on their original subscription.

DR. D. W. MONTGOMERY, in opening the discussion on "The Contagiousness of Tuberculosis in Relation to Public Health," said: The general practitioner of extensive experience was more capable of discussing this subject than a specialist. The contagiousness was, perhaps, the most interesting point in this disease. A new interest had been created on account of Koch's discovery of the tubercle bacillus. Professional opinion was unanimous as to the cause of the disease. It was difficult to say how contagion was carried, and it is as yet hard to decide whether any particular good had resulted from Koch's discovery. There is said to be a decrease of the disease in Philadelphia, and this may be due to many tubercular cases seeking more favorable climates in Colorado and in Southern California. They go to these places and they die there. The public must be educated up to the point of hygienic care of the affected. Tuberculosis is much more contagious than leprosy, yet people have a far greater dread of the latter disease. For years the profession had said that consumption was not contagious. Consumptives, unchecked, bequeath their clothes "by will" to various friends and relatives. If public sentiment were aroused, it would be a powerful lever in decreasing this disease. This force has decreased leprosy, especially in Norway. The process, however, for driving this knowledge into the public was very slow. Regarding the liability of contracting the disease from food, the speaker said that the viscera may be a source of contagion, but he thought it very improbable that the disease would be contracted from eating beef. Dr. W. H. Welch, of the Johns-Hopkins University, believes that the low death rate amongst the east-side New York Jews depended on their extra caution in the use of meat. The more intimate association of our race with animals might also explain our increased liability, as Hebrews seldom associate with them. That milk may be a source of contagion seems probable. In several cases cows known to have been diseased seemed to have caused tuberculosis in children. The sputum is the great source of infection, and information here is, perhaps, more necessary than in any other of the causes. Sputum is found everywhere, and when dried and disseminated through the atmosphere, was a ready source of contagion. Regarding the great prevalence of the disease, it had been found at the Vienna Hospital that in 100 autopsies 66 of the patients were tubercular; of these, 35 had died of the disease, while in 10 it was latent.

Dr. H. M. Sherman, speaking of the prevalence of tuberculosis, said there was 1 case in every 286 of those affected between the ages of 1 and 17 years, in San Francisco. There was one case in which he felt tolerably certain he could trace the infection from a tubercular step-father to the child.

Dr. J. Rosenstirn said the discovery of the bacilli, no doubt, tended to decrease contagion, and this was a most important step. If the danger of contagion could be impressed upon the general public, and upon the management of public institutions, it would be a great step in advance and the benefits would be immense. No hygienic measures were adopted in such Southern California institutions as he had visited. The cuspidors were in a fearful condition; sputum was on the floor, etc., and the general want of care, and negligence was a pitiful sight. Patients there should be warned by placards on the walls, and physicians in charge of public institutions should be held responsible for these conditions. The comparison of Dr. Montgomery of the relative contagiousness of leprosy and tuberculosis was absolutely correct. If we were as rigid in the management of cases of tuberculosis as we are in cases of leprosy, people would probably rebel, and we ought, therefore, to relax our efforts. These should rather be directed to hygienic measures and to prevent the spread of the disease. Physicians should report their cases to the Medical Health authorities. The latter should then send monthly circulars to these people, instructing and warning them; they would thus be more or less rapidly educated. It takes a long time to thoroughly impress these views upon the people. Dr. Sherman's statement that 1 in 286 cases of disease in children were tubercular, must relate to surgical tuberculosis only.

Dr. Phillip K. Brown said there was a society in Philadelphia that issued two kinds of circulars and distributed them everywhere, among factory employes, mill hands, etc. One circular stated the methods for avoiding contracting the disease; the other directed how to avoid conveying the disease to others. Michigan has now a law requiring physicians to report all tubercular cases to the Health Officers. The speaker believed the profession responsible for the slow moulding of public opinion. A prominent Boston physician was opposed to the public reports because it causes the patient to lose all hope, and therefore lessens his liability to recover.

Dr. E. E. Kelly thought the origin of the Philadelphia Society was an ordinance requiring physicians to report all tuberculous cases to the Health Office. According to many investigators, dry dust, sputum, etc., are great carriers of the contagion. It was therefore necessery to warn people to destroy these sources of infection. Rooms where such patients die should be disinfected by the Sanitary authorities. He believed he had seen patients who had contracted the disease from living in houses where cases had died. He thought that the public report of all tubercular cases was going a little too far. Thorough milk inspection was certainly desirable.

Dr. Montgomery said he thought Dr. Sherman meant one in 286 of all cases between the ages given were tuberculosis.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, June 16, 1894.

The President, **John F. Morse, M.D.**, in the Chair.

In the absence of **Dr. W. S. Thorne**, his paper, "A Report of a Case of Cesarian Section" [published at p. 550], was read by the Secretary.

Dr. W. Watt Kerr: I can probably add a little more to the history of this case, having been in attendance with Dr. Thorne. The patient was an Italian woman, rather short in stature, under 5 feet, who had been sent to the hospital from San Rafael. Labor had begun Tuesday, the woman being attended by a midwife. As time wore on and no progress was made the midwife became frightened and sent to San Rafael for a physician. Dr. W. J. Wickman arrived at the bedside at 1 P. M. Thursday. Recognizing at once the nature of the case he advised her removal to San Francisco for operation. This was finally agreed to, and late Friday afternoon she was brought into the hospital, the operation being performed early Saturday afternoon. On making a vaginal examination the promontory of the sacrum was found far forward, much resembling the child's head, and the opening would just admit two fingers. The operation was done without mishap, the placenta fortunately being untouched when the uterus was opened. Ergotin was given, and before the patient was removed from the table the uterus was firmly contracted. The total loss of blood from vagina, placenta, and operation was certainly very small, not amounting to more than two ounces.

Dr. G. F. Shiels: There is one point or question not touched by the gentleman in this very interesting paper; that is, Why was the uterus allowed to remain? The impossibility of a natural birth ever taking place was established, and had the uterus been removed there would have been no further pregnancies. Why subject the patient to the danger of another section? The incision was large enough, and it would have been best to have removed the uterus and ovaries at once; it would not have increased the danger to any great degree.

Dr. Kerr: There are two reasons why this was not done: one was the patient's exhausted condition; another was the fact that neither the husband nor any relations were present to give their consent. It was discussed, however, but deemed best to get the husband's consent first. Dr. Thorne contemplates removing the uterus and ovaries, and is only waiting for the consent of the relatives to do so, but this may not be so easy to get, both from social and from religious reasons.

Dr. Geo. Gross: I believe with Dr. Shiels that it would have been proper to have extirpated the uterus *in toto*.

Dr. M. Hildebrand: Under the condition of exhaustion, as stated by Dr. Kerr, I think I would have hesitated also; but think if consent could have been obtained, the ovaries simply should have been removed instead of making a total extirpation, as suggested by Dr. Shiels.

Dr. Geo. Gross read a paper on "Symphysiotomy; with a Report of a Case." [Published at p. 538.]

Dr. Dudley Tait: I have listened with satisfaction to the two cases just reported, and think that in both instances the proper method was used. Regarding symphysiotomy, more than a century has elapsed since the French obstetrical surgeons brought it to the front, and for more than a century it has been ridiculed and deemed illogical even by the French school. Its rehabilitation may be credited to the glory of the Italian school. At the recent International Congress at Rome its great value was dwelt upon by several eminent men, especially Morisani and Leopold; and that there is value in symphysiotomy cannot be doubted. The statement of Leopold that it could not be adopted by the general practitioner has been proven not so. Looking over the medical journals of the past two years containing cases of symphysiotomy performed by general practitioners, we find the list monotonously long. Some contend that there is an irreparable lesion at the sacro-iliac articulation; this is false where the separation does not exceed 5 to 6 cm.; therefore the statement of the "peculiar gait" does not hold. Cases are on record where symphysiotomy has been performed three times on the same person. Symphysiotomy will supercede and eradicate basiotripsy, cephalotomy, and perforation. In a case of pregnancy not at term where the conjugate is less than 7 cm., premature labor should be induced. If the pregnancy is at term, or labor has begun, complete dilatation should be awaited without rupturing the membranes, and version attempted, followed by extraction. If these measures prove unsuccessful, then perform symphysiotomy. The indications for the cesarian operation begin where those for symphysiotomy end; and each has its distinct indications based on the diameters of the pelvis. However, when both operations are permissible, I would give the preference to the cesarian operation for several reasons.

It is a very simple and easy operation. No time is lost in determining the proper term of interference. The risk is not greater, and the results are equally good, if not better. Sänger reported a series of 12 cases, all followed by recovery. The after-treatment amounts to nothing, and gives no anxiety.

Dr. G. F. Shiels: I do not believe in statistics; they can be made to prove anything. This comparison of woman to the lower animals is all wrong; the one is in an upright position, the other not. In woman the whole upper part of the body is held or supported on the sacro-iliac synchondrosis. In older women the joint may be ossified and it may be so even in younger ones; so the question of age enters here. If symphysiotomy is performed and the pelvis spread, we run great risk of injuring the sacro-iliac synchondrosis. As this operation becomes more and more popular, we shall see many cases of irreparable injury done. In Dr. Gross' case there was no motion after the operation. Even if we find slight motion resulting from it and watch the case we will find after a time, that it increases, and loss of power in standing and locomotion to a certain extent will be manifest. Before doing the operation it would be best to ascertain, if possible, the condition of the sacro-iliac synchondrosis. I am inclined to think that we should put a brake on this "fad" of symphisiotomy. The greatness of the men who have performed it, has nothing to do with the case. As an example, take Lister: For years he swore by the spray, and subsequently he assumed a directly opposite position.

Dr. W. Watt Kerr: Symphysiotomy is a very good operation where we can rely on it. It is based on the size of the pelvis, but we have also an unknown quantity, the child's head and its bony formation. We cannot estimate this, and if, after a symphysiotomy, we have to do a section, the first operation is no step to the second. If we cannot deliver with the forceps and the child is all right, we would dislike to do symphysiotomy and then a laparotomy. The danger is slight from cesarian section, and we should certainly look for a good recovery. That the symphysis pubis does unite under favorable conditions, we must admit. In one case in my own practice, while delivering a primapara with forceps, the pelvis widened and the giving way could easily be felt. Two weeks later parts of bone perforated the urethra, causing a fistula. There was some lameness for a time, but finally a complete recovery ensued.

Dr. Gross: The movement of the pelvis gives us the solution of the question. We would have to separate the pelvis 3 cm. to break the sacro-iliac synchondrosis, so, by measuring, we know just how far to go. Now, as we have better antiseptic precautions, we get much better results. In certain cases, symphysiotomy is the only operation; take, for instance, the after coming head. Symphysiotomy is far simpler than cesarian section and no special appliance is necessary. The case spoken of by Dr. Kerr shows that nature teaches us some things, and that the healing process will go on if proper care is taken.

Dr. W. F. Arnold, U. S. N., read a paper on "Two cases of Unclassified Infection" [*vide* Medical Times, vol. viii, p. 469].

Dr. D. W. Montgomery: These are very interesting cases. Some years ago Dr. Carpenter brought to me some sections of liver and kidney. On examination they were full of holes, as the doctor describes, and under the microscope no bacilli were found. The sections had been removed from the body of a prostitute who had been brought into the morgue. She was very edematous, with a brawny skin, and though the organs were so badly decomposed, she was yet warm. Dr. Sherman, who had seen a case in Bellevue, saw this case also. Bremer reports the case of a prostitute dying from malignant edema. The death is one of the utmost distress, with perfect consciousness to the last. Dr. R. W. Taylor, of New York (I believe it was), operated upon the deep urethra; the patient became rapidly edematous and died. When Dr. W. E. Taylor was Coroner here, there was a case brought into the morgue, in an advanced state of decomposition and still warm. Dr. Taylor was loath to believe that it had been dead so short a time. A man in San Rafael fell and sustained a compound fracture of the leg, and in a short time died from a rapidly advancing edema and the other symptoms. The edema advances with tremendous rapidity almost at a visible speed; it is impossible to head it off by an amputation. Its importance from a medico-legal aspect is shown, as people might keep a body a long time and then warm it. It is important to note that if a person is wounded by a rusty nail in garden mould or in the moist low soil of gardens, etc., and a rapid case of blood poisoning sets in, it is probable that it is a case of malignant edema. The most radical measures should be taken to insure absolute cleanliness of the wound.

Dr. Arnold: Dr. Welch's report in the *Johns Hopkins Bulletin*, embraced some hundred cases. Many cases occurred during the Crimean war, and were frightful. The case reported by R. W. Taylor was undoubtedly a true case of malignant edema. If we inoculate a mouse with garden mould the lesion is local. The bacillus is one of many that discolorize by Gram's method. My measurements were very close. Where we have a gas in connection with edema, it is of the inflammable type, marsh gas type, for instance.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular meeting, July 2, 1894.

The President, F. Z. Bazan, M.D., in the Chair.

New Member.—W. M. Thorne, M.D., was duly elected a member of the Society.

Dr. Frank Fischer read a paper, entitled "Infantile Spinal Paralysis; a Study of its Etiology." [To be published.]

Dr. W. F. Cheney said that in studying the etiology of any disease, the natural method is to reason from symptoms back to their causes. In infantile spinal paralysis, the most prominent feature is the paralysis. The cause of the paralysis was discovered in 1886, when it was shown that there were certain constant changes in the spinal cord. The ganglionic cells of the anterior horn are destroyed and the horn itself is replaced by fibrous tissue. The next question is as to the cause of these changes. It is generally accepted to be an inflammation, whence the name poliomyelitis. The disease has an acute onset, with elevation of temperature, restlessness, etc. As for the cause of the inflammation, several things have been suggested—hemorrhage, traumatism, infectious irritants. That hemorrhage might be the cause of the degeneration is an old notion. It may be due to the influence of very hot weather or sudden cooling after intense heat. Overexertion, such as rapid walking, leads to an increased blood supply of those parts of the cord presiding over the lower extremities. It has been thought that there might be some infectious agent, such as there is in pneumonia, scarlet fever, etc., or some particular poison. Such has never been found. However, it is possible that ptomaines from some particular organism might have a selective action. The cause, whatever it may be, is almost certainly physical, for psychical causes probably have no effect. There is no evidence that reflex convulsions cause inflammation of the centers. It is easier to assume a congestion leading to a hemorrhage.

Dr. L. C. Lane said the history of such cases is characteristic. The mother will say, "My child was perfectly well when it went to bed, and awoke in the night with fever. In the morning it couldn't move one of its legs." He referred to a case in which the paralysis affected one leg and the opposite arm. Often the paralysis is not observed for some days. In regard to treatment, he had learned from his cases that it is not very satisfactory. In many cases, in spite of all that was done, the leg remained useless, though it generally grew fairly well. In a few recent and mild cases mechanical appliances are occasionally of benefit, but in severe cases they are rather a detriment, because of lack of power to use the limb. The constant current has benefited some cases.

Dr. Basil Norris referred to a case in a mulatto child, 11 or 12 months old, whose father was a messenger in the War Department. This child was a great crawler. He had noticed the same thing in other cases. Vigorous children, eager to get about, are restrained from getting on their feet too early, whence their crawling powers increase. It is probable that the irritation of locomotion in the prone position has some bearing on the causation of this disease. He advised mothers to let their children walk as early as possible. If the paralyzed muscles respond to the galvanic current, even if they fail to contract with the faradic, the prognosis is favorable.

Dr. Stanley Stillman said that as far as crawling is concerned, it seemed confirmative of the theory of congestion. He had seen a child crawl faster than another could walk. The pendulum has swung a little too far when there is sought an infectious cause of such a disease as infantile spinal paralysis. It is impossible to account for the clinical history and the peculiar localization of the lesion on any such supposition. The results of treatment are also confirmatory of this idea. If the cases show a tendency to get well, treatment will help a little, but those cases will get well anyhow. If not, treatment by electricity, massage, etc., etc., will do next to nothing. The whole subject of extravasation of blood in children is not settled. In Potts' disease, etc., there is probably a slight extravasation, to which an infectious agent is added. The cause of poliomyelitis anterior is mechanical rather than infectious.

Dr. S. M. Mouser said he was inclined to think the notion of infectiousness in this matter a little far-fetched. He should like to see the microörganism. The instance cited in the paper, in which 1 per cent. of the population were affected, is probably better accounted for by assuming some endemic cause rather than a direct infection.

Dr. R. W. Murphy referred to a case in which the mother had syphilis, which might have had something to do with it. In two other cases the mothers were addicted to alcohol during pregnancy. These cases are most common, as the paper has said, in summer. In some there is a malarial element. Probably the changes are due to hyperemia rather than hemorrhage. He had found the iodide of potash to do more good than anything else; also, of course, employed rubbing, bathing, out-door exercise, etc.

Dr. C. F. Griffin said the suddenness of the onset of the disease is an argument against the infection theory. The younger the child, the shorter the period of incubation. The paralysis is not the disease, but a sequel. We must not ignore the fever, which is the strong argument for the infectious nature of the disease.

Dr. Fischer, in closing the discussion, said: The question, "Why, if the disease is infectious, does it not attack adults, as do measles, scarlatina, etc.?" might be answered by the fact that occasionally poliomyelitis anterior does attack adults.

SPECIAL CORRESPONDENCE.

LONDON.

The Hot Wave in New York.—Naupathia.—London as a Medical Center.—Its Medical Museums.—Jonathan Hutchinson's Clinical Museum.—The Museum of the College of Surgeons.—Unique Specimens.—London Hospitals.—Lawrie on Chloroform Anesthesia.

California may labor under the disadvantage of being remote from New York city, and, conversely, the latter city suffers a similar disadvantage in being so remote from California. The burden of my plaint is essentially climatic. The heat during the latter part of my sojourn in New York city was intolerable, and cases of insolation were rampant. I can hardly believe that any unacclimated person escaped the minor manifestations of sunstroke, such as head constriction, nausea, and malaise. The pathogenesis of insolation is certainly obscure, although there is good reason to suppose that it is merely a mode of intoxication, provoked by suppressions of the cutaneous secretions; at any rate, free perspiration will surely inhibit its manifestations.

Before crossing the ocean, I fortified myself against impending sea-sickness, by consuming all the literature I could possibly obtain on the subject. The following was the resultant knowledge which I elicited. While authors differed materially in the pathogenesis of the affection, the opinions were unanimous in signalizing sea-sickness as a very disagreeable condition. It is a sad commentary on scientific medicine, when one can conscientiously say: "My physician can give me nothing to cure sea-sickness." Empirical therapeutics shares the same rebuff when antithetic remedies are accorded like results. While one physician will solemnly recommend his patient to go on board with an empty stomach, another will give the sapient advice to go on board with a full stomach. Another recommends ice, and still another hot water. The results usually tally, however, insomuch that the patient generally follows the advice of his physician and gets sea-sick. Bromo-chloral, a mixture of bromide of potash and chloralamid, has lately been vaunted, on good authority, as a sovereign remedy for *nausea marina*. Its action is similar to that of any other hypnotic. It makes the recipient oblivious to external impressions. It is no more a specific than opium or any other narcotic. There is a time-honored tradition in medicine that must be revoked, a tradition which specifies sea-sickness as a good thing for the health. If the sequences of sea-sickness could be enumerated by scientific inquiry, the fallacy of this tradition would only be more emphatic, aside from the fact, that it would prove more rational to evoke, in proper dosage, the essentials of sea-sickness by the administration of emetics.

London is unquestionably a great commercial center, but not a medical center. There are too many medical subcenters with no inclination toward centralization, a fact which the American physician going to London at once perceives. The distances between the educational institutions are so great, that the post-graduate courses in medicine are very poorly attended. To the American physician, who contemplates taking a post-graduate course in London, I cheerfully offer the following advice: Study the topography of the city for at least six months, and after you think you have mastered it, study it another six months, then attend a post-graduate course in New York. London has this insuperable advantage over New York, to the superficial observer: it has an environment of respected medical antiquity. Comparisons are, of course, invidious; for while the United States can be proud of the eminence attained by her medical men, she must concede to Great Britain many advantages in the direction of higher universal medical education.

The medical musea in London are manifold, each hospital usually possessing a very creditable collection of carefully prepared specimens. There are two musea, however, to which I will direct attention; viz., the Clinical Museum of Jonathan Hutchinson and the Museum of the Royal College of Surgeons. The former is the private property of Jonathan Hutchinson, a man of versatile attainments, equally renowned as a surgeon, oculist and dermatologist. The arrangements in this museum are certainly novel. Part of the plan is to gather from various sources published illustrations of disease and to bring them together in classified juxtaposition. There are no jar specimens. No one should go to London without visiting this museum. Here may be seen the original drawings, illustrating the characteristically deformed teeth of hereditary syphilis and mercurialism. The museum of the Royal College of Surgeons is in reality a series of musea. The museum devoted to the zoölogy of invertebrated animals is not less complete than the museum showing the osteology of extinct vertebrata, nor more complete than the medical museum, which is truly a marvel in arrangement. One could profitably devote months to a study of its contents and yet find at the termination of that time that he had only begun his work.

The interest attached to these specimens is not only didactic, but historic. Let me cite only a few specimens, jotted at random: (1) One hundred needles, extracted from the body of a Danish Jewess. (2) An iron gun breech and screw, which, by the bursting of a gun, were driven into the head of an officer in India. They remained lodged in the ethmoidal cells and nasal fossæ, with part of the breech and rivet protruding through the fore part of the palate into the mouth, till the time of the patient's death, which happened 7 years after the accident. (3) An elastic catheter, removed from the connective tissue between the uterus and rectum, where it had remained for 20 months after having been placed there by a quack, for the purpose of producing an abortion. During the time of its lodgment, the patient presented characteristic symptoms of hip-joint disease. (4) Cast of a stone removed from the abdominal cavity. The patient, a sailor, suffered from stricture of the urethra. He was in the habit of passing a glass bottle into the rectum for the relief of retention of urine. One day retention of urine occurred, and, not possessing a bottle, he inserted a belaying pin. This not having the desired effect, he went on shore, and, picking up a pebble the size of cast, he passed it into the bowel. This stone, after unsuccessful attempts at removal, passed through the ruptured bowel into the peritoneal cavity. (5) Three clasp knives swallowed by a soldier and voided *per anum*. Human ostriches are not uncommon even outside a dime museum. The other day an inquest was held at the County Asylum, Lancaster, where an individual swallowed 192 flooring nails, weighing 1 pound, 9½ ounces.

The hospitals in London are numerous. Some are modern, but many of them are old. The former, of course, embrace all the improvements of modern hospital construction, while the latter are superannuated and are naught else but foci for septic infection. It is not difficult to presage the evolution of the future hospital. It will be readily separable into its constituent parts, so that ideal cleanliness can be attained. I visited the Brompton Hospital, with the hope of eliciting some information relative to the treatment of consumption. This hospital is simply an asylum for the unfortunate sufferer, for although they have distinguished physicians, such as Williams and Bruce, on the visiting staff, the latter assured me they did nothing in the direction of medication, sustaining the patient by suitable nourishment only, and thus combating the disease.

At an extra meeting of the Royal Medical and Chirurgical Society, Surgeon Lieutenant-Colonel Lawrie presented a communication on chloroform anesthesia. The propositions set forth in the paper were essentially as follows: (1) Chloroform has no direct action upon the heart. Proof of this was demonstrated by an enlarged photograph of a tracing of a cross circulation experiment, in which chloroform was sent to the heart alone and produced no effect whatever. (2) The usual effects of chloroform are produced by its action on the brain centers. (3) Chloroform anesthesia alone is free from risk. The general tenor of the paper was to show that it is useless and dangerous to take the pulse as a guide to the effect of chloroform. He contended that the experiments performed by the Hyderabad Commission proved that death was due to respiratory failure, and that the essential point to remember was that, during chloroform administration, the respiration must be watched, and that the condition of the pulse was quite subsidiary. The author admitted that chloroform irritates and destroys protoplasm in the same way as any other irritant when injected into the muscle; but this question could be altogether ignored in chloroform poisoning by inhalation. The communication evoked considerable discussion among such men as Gaskell, Brunton, Horsley, Newman, and others. Some occupied themselves with the demolition of the propositions set forth by the author of the paper on the ground of incomplete experimentation. Others contended that the heart and not the respiration should be watched; a statement which was vigorously opposed. I do not remember anyone having the hardihood to say that both should be watched. The discussion was an unquestionable demonstration of the fact that laboratory and clinical results do not always tally. One individual present justified his right to speak beyond the usual time allotted for discussion, on the grounds that he was present when chloroform anesthesia was first used in battle. This personal reminiscence was undoubtedly of great interest to the speaker, but, failing to arouse any enthusiasm among the members, he was kindly reminded by the President to speak on, and not about, the subject. At this meeting I do not recall anyone present congratulating the author on the excellence of his paper; in fact, the discussion was interesting because it was brief. A medical man who has truly something new or original to say is what I would term dyspneic, while his long-winded antithesis suffers from mental sterility and vocal incontinence. Medical meetings are frequently prosaic affairs, for the reason that they aggrandize the speakers and ignore science. The limit placed on discussions cannot be too short. Communications to medical societies should be divested of their usual ornate raiment. The delectable pith, conclusions, without its unnecessary accompaniments, is quite enough. A. ABRAMS.

LONDON, June 15, 1894.

CORRESPONDENCE.

BRISTOL.

[FROM OUR OWN CORRESPONDENT.]

The Sixty-second Annual Meeting at Bristol.—Its Success.—A Defect in the Organization of the Association and its Dangers.—Epidemic Influenza and Bacteriology.—Diphtherial Antitoxin.—"The Ladies."—Visitors.—Shall we Meet in Canada?

The sixty-second annual meeting of the British Medical Association at Bristol, though not a large one, was one of the most agreeable of the many which I have attended. The arrangements made by the local committee were most admirable, both in what concerned the sectional work and the social aspects of the meeting. The greatest credit is due to the local General Secretary, Dr. Markham Skerritt, physician to the general hospital, for the excellence of the provision which the organization of which he was the moving spirit had taken so much trouble to make. The only disagreeable feature of the meeting—for the weather, though uncertain, might have been worse—was the success which attended the efforts of a small clique to capture one of the general meetings at which the business of the Association, by a by-law which has become an anachronism, is supposed to be transacted. Immediately after the President, Dr. Long Fox, had delivered his opening address, the meeting adjourned from the morning was resumed, but it was then close on 10 P. M., and the greater part of the audience melted away, the majority to visit a conversazione given by the exhibitors in the "Annual Museum," an occasion which afforded an excellent opportunity to inspect the exhibits without devoting to that purpose some of the precious hours of daylight which the local committee had filled with engagements of business or recreation. In a very thin assembly of 40 all told, resolutions were passed committing the Association to a particular policy on questions on which there is known to be much difference of opinion, and as to which the time is not ripe for decision.

The next annual meeting of the Association is to be held in London, and there is a very strong feeling that unless something can be done to revise the regulations for general meetings before that, the Association will run the chance of being made a ridiculous spectacle for the metropolitan public. It should be recollected that the affairs of the Association are, under the new constitution, conducted by a Council elected by the branches at their annual meetings; the Council appoints committees, and it would only be according to constitutional precedent if these committees reported to the Council. Instead of this we have the anomalous state of things at present existing, under which these committees send in reports to the Council, by whom they are presented to the general meetings. The final absurd result is arrived at that the labors of a year, carried on by a committee specially selected by the Council, which itself is elected by an elaborate franchise designed with great care to insure complete representation to all the members of the Association who choose to avail themselves of the franchise, is kicked over after a few minutes discussion by a catch vote in a meeting of half a hundred persons whipped together perhaps in the interest of some particular fad-monger.

The address in medicine was given by Sir Thomas Grainger Stewart, who had attended at Windsor during the previous week to receive the honor of knighthood. The Professor of Medicine in the University of Edinburgh was given a particularly hearty welcome, and his address, which was taken up with the subject of epidemic influenza, was listened to with much interest. The sneering tone in which much recent bacteriological work is commonly spoken of in this country by "the leaders of the profession," finds an echo among the rank and file engaged in general practice in country places, and Sir Grainger Stewart's frank acceptance of the bacteriological discoveries as to influenza will have a far-reaching effect, when it is seen that he relies upon them, to a large extent, not only in making suggestions as to prophylaxis, but also in seeking to explain the symptoms and complications of the disease.

In the Pathological Museum, which was arranged with much skill in a large room in the University College, was a collection of cultures of microörganisms, pathogenic and non-pathogenic, which had been prepared in the temporary laboratory of the British Institute of Preventive Medicine. This was one of the most complete collections ever brought together, and comprised a quite wonderful series of chromogenic bacteria. The cultivations were made by Mr. Plimmer and Dr. Blaxall, and Dr. Ruffer, the Director of the Institute, was also present and assisted in the demonstrations, which were given twice a day. I may digress a moment to say that the first report of the Institute, issued recently, states that it is hoped that the diphtheria antitoxin may shortly be prepared at the Institute in quantity sufficient to render it possible to supply all demands. The trials already made have been most successful, and there can be little doubt that when the antitoxin can be taken into general use it will shortly be recognized, even by the most pig-headed anti-vivisectionists, that bacteriology and bacteriological chemistry have in this, presented humanity with a real remedy for the terrible scourge which seems capable of defying the best sanitary precautions. It is a curious irony that at this very meeting at

Bristol, the Section of Public Medicine discussed at some length the question whether diphtheria has any connection with insanitary conditions; it is true that the general opinion was in favor of an affirmative reply, but the mere fact that it was thought necessary to raise the question shows how near despair our sanitary officials have come in their task of attempting to limit the spread of the disease in towns.

This was the first occasion on which ladies (with the exception of two ladies elected many years ago) had the right to take part in the discussions of the sections. The privilege was claimed by several ladies in the Section of Obstetrics and Gynecology, where Mrs. Sharlieb, M.D., who practised at one time in India, read a very excellent paper on hysterectomy. But in the Section of Medicine they were silent, in spite of the pressing invitation of the President, Dr. Frederick Roberts, who invited them to contribute to the debate on the subject of functional diseases of the heart, on the ground that they and their sisters had been, at one time or another, responsible for many functional disturbances of the organ. This sally was much applauded, and appeared to have been taken in good part by the ladies themselves.

Among the prominent men who attended the meeting were the President of the Royal College of Physicians of London (Dr. Russell Reynolds), and Sir Spencer Wells, who, I regret to say, appeared to be in very indifferent health. We had the pleasure of welcoming a considerable number of visitors from the other side. Among others, Dr. Geo. M. Gould, the editor of the *Medical News*, Dr. Risley, Dr. Osler, Dr. de Schweinitz, and Dr. Northrup, from the United States, and Dr. Blackader, and a numerous contingent from Montreal. There was some talk of the possibility of an invitation to meet, before many years are over, in Montreal, and if the difficulties which the length and cost of the journey appear to interpose can be shown to be less serious than is generally supposed, there is every probability that the invitation, if given, may be accepted.

REVIEWS AND NOTICES.

THE F. A. DAVIS Co., of Philadelphia, will in September issue a new book on "Practical Urinalysis and Urinary Diagnosis," for the use of practitioners and students. The book will contain numerous illustrations, including colored photo-engravings. Charles W. Purdy, of Chicago, is the author. This work will be in one volume, of about 350 crown-octavo pages, in two parts, subdivided into twelve sections, and an appendix. Part I is devoted to the general subject of Analysis of Urine; Part II is devoted to Urinary Diagnosis. In the appendix is presented the highly important subject of Examination of Urine for Life Insurance. This is the first American work of a comprehensive character, for more than a decade, in this department of practical medical science.

ESSENTIALS OF PRACTICE OF PHARMACY ARRANGED IN THE FORM OF QUESTIONS AND ANSWERS, PREPARED ESPECIALLY FOR PHARMACEUTICAL STUDENTS. Second edition revised by Lucius E. Sayer, Ph.G., Professor of Pharmacy and Materia Medica of the School of Pharmacy of the University of Kansas. Saunders' Question Compends, No. 18. Philadelphia: W. B. Saunders. pp. 200. Price, $1.00.

We are pleased to see that the early appearance of a second edition proclaims the success which we hoped for this work. The present edition, besides bringing the text to correspond with late editions of the United States Pharmacopeia, also contains additional information regarding drug and plant analysis, formulæ of organic carbon compounds used in medicine, testing of inorganic chemicals, etc., all of which enhances the value of this already useful manual.

HEWSON'S ANOMALY BLANK. Devised by Dr. A. Hewson, of Philadelphia. P. Blakiston, Son & Co., Philadelphia, Pa.

This blank is for the use of dissectors and is designed for recording any anomalies or variations that may be met with. The blank is arranged so as to designate the name of the dissector and the general characteristics of the subject; then spaces are provided for noting systematically any peculiarities in the various tissues and organs of the body. These blanks are already in use in the dissecting rooms of Cooper Medical College and in the Medical Department of the University of California. The publishers state that they have supplied them to thirty-three medical colleges. As they are designed particularly to be used with Morris' Anatomy, the publishers offer to supply them in any required number free of charge, inserting the name of the professor or demonstrator and of the college.

A TEXT-BOOK OF THE DISEASES OF WOMEN. By Henry J. Garrigues, M.A., M.D., Professor of Obstetrics in the New York Post-Graduate Medical School and Hospital; Gynecologist to St. Marks Hospital, New York City; Gynecologist to the German Dispensary in the City of New York, etc. With 310 engravings and colored plates. Philadelphia: W. B. Saunders. Price, cloth, $4; sheep, $5.

This work consists of two divisions—the one devoted to the development of anatomy and physiology of the female genital organs, to etiology, examinations and treatment in general, and to menstruation and leucorrhea; the other to a consideration of the various special diseases of women, an arrangement especially adapted to the requirements of the student and of the general practitioner. Criticism is disarmed by the judicial, thorough, comprehensive, and scholarly treatment of the entire subject. As a text and reference book, Dr. Garrigues' work has no superior, if an equal, in recent gynecological literature.

A MANUAL OF THERAPEUTICS. By A. A. Stevens, A.M., M.D., Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pennsylvania; Demonstrator of Pathology in the Woman's Medical College, Philadelphia, etc. Philadelphia: W. B. Saunders. pp. 436.

This little volume is well up to date and as it includes a short account of all the recent remedies, it will be found a very convenient source from which either student or practitioner may make a rapid revisal of his knowledge of therapeutics. It certainly cannot take the place of the larger works upon the subject, and does not pretend to do so; but its systematic arrangement and consise form make it eminently useful for the purpose above stated. There are one or two inaccuracies which, while they may not be of very great importance, may, nevertheless, lead to confusion. The old diuretic pill of squills, digitalis, and blue mass, is described by the author as *Niemeyer's pill;* it may be true that Niemeyer introduced this combination, but the pill generally known as *Niemeyer's* consists of digitalis, quinine, and opium, and is most frequently used in the treatment of phthisis. We believe that the book will become popular.

A PRACTICAL TREATISE ON NERVOUS EXHAUSTION (NEURASTHENIA); ITS SYMPTOMS, NATURE, SEQUENCES, TREATMENT. By George M. Beard, A.M., M.D. Edited with notes and additions, by A. D. Rockwell, A.M., M.D., Professor of Electro-Therapeutics in the New York Post-Graduate Medical School and Hospital. Third edition, enlarged. New York: E. B. Treat. pp. 262. Price, $2.75.

This work has been so long before the profession that it does not require any introduction. The change in the present edition essentially consists in the addition of a chapter upon the etiology and pathology of nervous exhaustion, in which the editor clearly shows the relation between neurasthenia and the competitive anxieties of business, and further demonstrates the fact that the greater prevalence of the malady in America, as compared with Europe, is due to climatic influences and not to primary differences in the individual, as the American in Europe can adapt himself to the ways of the country and live in a manner that would be absolutely impossible in America. The value of such observations is considerable, as they suggest lines of treatment, and account for the prevalence of the disorder in the United States.

A TREATISE ON HEADACHE AND NEURALGIA, INCLUDING SPINAL IRRITATION AND A DISQUISITION ON NORMAL AND MORBID SLEEP. By J. Leonard Corning, M.A., M.D., Consultant in Nervous Diseases to St. Francis Hospital; with an Appendix. Eye Strain, a Cause of Headache. By David Webster, M.D., Professor of Ophthalmology in the New York Polyclinic; Surgeon to the Manhattan Eye and Ear Hospital, etc. Illustrated. Third edition. New York: H. B. Treat. pp. 276. Price, $2.75.

In addition to the subjects mentioned in the title of the book, the author also discusses spinal irritation, sleep, and eye-strain as a cause of headache. The interesting feature in this edition is a chapter upon the condition of the action of remedies upon the brain. By this method the writer endeavors to obtain the concentrated influence of remedies upon the brain instead of a diffuse effect throughout the entire system. The method depends upon the contingency of the cerebral cortex upon the carotids and jugulars for its main blood supply; the rapidity with which medicaments are absorbed through the nasal mucous membrane and carried to the brain; the ease with which the cerebral circulation is retarded by pressing upon the jugulars. The nasal mucous membrane is cleansed with warm water, the medicament injected, and compression made on the jugulars by means of pneumatic cups. Patients treated by this method claim that relief is both more rapid and more prolonged. Certainly the method holds out considerable promise, and we would advise our readers to purchase the book and study the subject in detail.

ESSENTIALS OF PRACTICE OF MEDICINE; ARRANGED IN THE FORM OF QUESTIONS AND ANSWERS. PREPARED ESPECIALLY FOR STUDENTS OF MEDICINE. By Henry Morris, M.D., late Demonstrator Jefferson Medical College, Philadelphia; Visiting Physician to St. Joseph's Hospital, etc. With a very complete Appendix on the Examination of Urine, by Lawrence Wolff, M.D., Demonstrator of Chemistry, Jefferson Medical College. Colored (Vogel) Urine Scale and numerous Illustrations. Third edition, revised and enlarged by some three hundred Essential Formulæ, selected from the writings of the most Eminent Authorities of the Medical Profession. Collected and arranged by William M. Powell, M.D., Attending Physician to the Mercer House for Invalid Women, at Atlantic City, N. J., Saunders' Question-Compends, Nos. 8 and 9. Philadelphia: W. B. Saunders. pp. 374—48—66. Price, $2.00.

This volume is of the "Saunders' Question-Compend Series," and as it has reached a third edition within three years, there cannot be any doubt but that it has supplied a want of the medical student. The book is arranged in the form of questions and answers relating to the symptoms, physical signs, pathology, diagnosis, and treatment of the more common diseases, and is admirably adapted to the purpose of a student testing his own knowledge, and will also be found extremely useful in directing attention to the salient points in the subjects considered. In such a work we cannot expect the detail of a text-book, but there are some omissions which should be remedied in future editions: for example, in the treatment of dilated stomach, no reference is made to washing out the stomach, while in chronic gastritis, it is said that washing by means of the stomach-pump gives temporary relief, the siphon method, which is practically the only clinical method now in use, not being mentioned. The appendix on urinary analysis makes the volume one of our best clinical companions.

THE ART OF PRESERVING HEALTH; OUTLINES OF PRACTICAL HYGIENE, ADAPTED TO AMERICAN CONDITIONS. By C. Gilman Currier, M.D., Visiting Physician to the New York City Hospitals. New York: E. B. Treat, pp. vii 468. Price, $2.75.

A single volume of this size must not be expected to exhaust the subject in its present state of development. The work is written in language free from technicalities, and is well adapted for popular reading, More space (41 pages) is devoted to soil and climate than is usual in books of this scope, but the matter is interesting and valuable, and no one topic is excessively prolonged. It is impossible to criticise the author on all subjects treated, and we must therefore select some specimen passages. In regard to cemeteries, he differs from most other writers, though he acknowledges that the germs of tuberculosis and cholera, as well as those of anthrax, may survive for a long time, and may be brought to the surface by earth-worms. Few would assent to the following declaration: "In this country, as in Europe, the water of wells and springs in burying-grounds is usually found, on careful analysis, to be in every respect purer than the average drinking water that people use with safety." It is pointed out that ordinary sewer-air is less impure than the dusty air of streets in cities, and that the most dangerous constituent of sewer-gas is the illuminating gas which has escaped from the mains running near sewers. The author seems not to be acquainted with the unsavory emanations from the sewers of

San Francisco, which is other than hydrogen or ammonium sulphide, and if possible more offensive, and whose summer exuberance reconciles the citizens to the ocean gales. He allows small importance to the effect of ordinary sewage on streams, unless it contains disease germs. This view will be substantially correct until the population of our country becomes much more dense, and manufacturing establishments have increased in like degree; but the question has already become a serious one in some of the eastern States. He recommends treating sewage with milk of lime, and observes: "The lime takes up carbonic acid that is in the sewage, and thus causes the lime *that is already present as a bicarbonate* to be precipitated as insoluble lime carbonate." The milk of lime, if fresh, is not carbonated at all, and if bicarbonated, how could it take up more CO_2 and then become a lower carbonate? The omission of the italicised words would leave some sense in the statement. His remarks on sewage-irrigation are appropriate, and they will be particularly interesting to Californians. He estimates the value of sewage annually wasted, in the usual method of disposal, as high as $5 *per capita* of the population; but this cannot mean over and above the cost of applying it to the land. Hitherto there has been no pecuniary profit in most cases, but at Berlin and at Pullman, Illinois, it is said there is some return beyond interest on cost of plant and expense of administration. It is to be hoped that Los Angeles will soon settle the economic side of the question for California. After frankly expressing what we regard as the principal defects of this book, we wish to say, as a whole, that it is to be commended as convenient and valuable to the general reader who wishes information on a subject which intimately concerns the welfare of all.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held August 7, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

William Burke. Los Angeles; Coll. Phys. and Surgs., Chicago, Ill., April 3. '94.
Sherman T. Davis, San Francisco; Med. Dept. Willamette Univ , Or., April 11, '85.
John C. Gosnell, Wellapa, Or.; Detroit Med. Coll., Mich., March 20, '88.
Howard Herrington, Santa Clara; Med. Dept. Univ. Mich., June 28, '94.
John Briggs Latta, San Diego; Med. Coll. of Ohio, March 3, '49.
Nicholas Molitor, San Francisco; Rush Med. Coll. Ill., March 31, '91.
Luther D. Scherer, Los Angeles; Chicago Med. Coll. Ill., March 16, '85.
George H. Steward, Marysville; Long Island Coll. Hosp., N. Y., June 14, '81.
Samuel Spencer Wallian, Helix; Bd. Regents, State of N. Y., May 29 '83.
Conrad Weil, San Francisco; Univ. of Bern, Switzerland, February 24, '90.
Joseph Suley Wheeler, Penryn; Coll. Phys. and Surgs., Edinburgh and Glasgow, Scotland, January 22, '91.
Chas. H. Whitman, Los Angeles; Coll. Phys. and Surgs., Chicago, Ill., March 25, '90.
Harrison Akers Wright, Klamath Falls, Or.; Med. Dept. Univ. Oregon, April 2, '88.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from July 21 to August 20, 1894.

Passed Assistant Surgeon W. F. Arnold, United States Navy, is relieved from duty with troops at Sacramento, California, and will return without delay to the Mare Island Navy Yard, California, and report to the commanding officer for further instructions. Par. 2, S. O. 81, Dept, of Cal., July 24, 1894.

In accordance with the provisions of paragraph 1662, army regulations, as amended by general orders No. 38, series of 1890, headquarters of the army, Lieutenant-Colonel William D. Wolverton, deputy surgeon-general, medical director, will proceed to and inspect the medical department at the following named posts: Vancouver Barracks, Wash.; Boise Barracks, Idaho: Fort Walla Walla, Wash.; Fort Sherman, Idaho, and Fort Spokane, Wash. Upon completion of this duty Lieutenant-Colonel Wolverton will return to these headquarters. Par, 4, S. O. 119, Dept. of the Columbia, July 30, 1894.

Lieutenant-Colonel Albert Hartstuff, deputy surgeon-general, medical director, is relieved from duty in this department, to take effect on the 3rd proximo, and will proceed to Chicago, Illinois, in obedience to paragraph 5, No. 148, headquarters of the army, adjutant-general's office. Par. 2, S. O. 66, Dept. of Cal., July 30, 1894.

The telegraphic instructions of this date to the commanding officer U. S. troops, Wallace, Idaho, directing Surgeon John D. Hall to return to his station, Fort Sherman, Idaho, and report to the commanding officer for duty, are made of record. Par. 2, S. O. 129, Dept. of the Columbia, August 16, 1894.

The telegraphic instructions of this date to the commanding officer Fort Sherman, Idaho, directing Assistant Surgeon William E. Purviance to proceed to Wallace, Idaho, and report to the commanding officer for duty with the troops in the field thereat, are made of record. Par. 3. S. O. 129. Dept. of the Columbia, August 16, 1894

Leave of absence for one month, to take place about October 1, 1894, with permission to apply for an extension of one month is granted First Lieutenant F. A. Winter, assistant surgeon.

Occidental Medical Times.

Vol. VIII. OCTOBER, 1894. No. 10.

REPORT OF THREE CASES OF LAMINECTOMY OCCURRING IN THE SERVICE OF PROF. C. N. ELLINWOOD, AT THE CITY AND COUNTY HOSPITAL, SAN FRANCISCO.

By Stanley Stillman, M.D.

Read before the San Francisco Medico-Chirurgical Society.

The following cases of laminectomy are reported, less to direct attention to the cases themselves, than to the procedure and the fact that extensive exposure of the spinal cord may be made, without great danger to the patient and without much subsequent deformity or weakening of the spinal column.

The procedure, for which we are indebted to Prof. Abbé, of New York, was the same in the three cases, and consisted, after thorough antiseptic preparations, in an incision 8 or 10 inches long on one side, and close to the spinous processes of the vertebræ. The incision was rapidly deepened to the posterior arches and the wound tightly packed with sterilized gauze for a few minutes, to check hemorrhage. The bases of the spinous processes were next exposed, one at a time, and the spines cut off close to the laminæ, with a sharp ¾-inch chisel, the intra and supra-spinous ligaments being undisturbed. The strong attachments between the inter-spinous ligaments and the ligamenta subflava were also severed with the chisel, after which heavy retractors were inserted and assisted by the chisel, used as a lever, and strong scissors to sever any remaining attachments, the flaps containing the spines and their connecting ligaments were forcibly pried and pulled aside till the tips of the transverse processes of the opposite side could be felt with the finger. Hemorrhage, though sharp, was not severe when partially controlled by pressure, and by the time the laminæ were sufficiently exposed it had practically ceased.

An opening into the vertebral canal was then made with a gouge through the eighth or quarter inch thickness of bone that remained where the spinous processes had been cut off, and enlarged by the rongeur forceps till the posterior surface of the dura was exposed to the desired extent. After whatever procedures that the particular case demanded, the dura, if it had been opened by accident or design, was carefully closed by fine catgut, and the operation completed by replacing the displaced flap containing the spines and ligaments and suturing it to its fellow with deep, buried sutures of catgut, the skin wound being closed without drainage and sealed with iodoform-collodion, and a plaster jacket applied.

The operation can be done quite rapidly. It exposes the cord fully posteriorly and as far laterally as the points of emergence of the spinal nerves, and is not accompanied by dangerous hemorrhage. The wound heals kindly, if kept clean, and the continuity of the supra-spinous ligament being unbroken, the resulting deformity is but slight. The severed spines reunite to their bases or to the sides of the trench that has been made by fibrous union, and apparently there is not much weakening of the column.

CASE I.—May C——, æt. 19; single; native of Denmark; occupation, domestic; admitted August 30, 1893. Twelve days previously patient fell from a window, a distance of 20 feet, striking on her right side in a pile of broken lumber and rubbish. She remained where she had fallen for over one hour, unable to move or speak, though conscious and suffering much pain. Immediately after being carried into the house she screamed and regained her power of speech—which unfortunately she has never since lost. Complete loss of motion and sensation was noted, from the level of the umbilicus down. At no time was she unconscious, though during the first week she was occasionally delirious. For the first three days after the accident she passed no urine; for the succeeding five days she was catheterized, since when she has urinated involuntarily. The bowels did not move till the eighth day, when an enema was given. The second movement was the result of an enema given the day after admission to the hospital. The enemata were repeated daily till the 7th of September, since when the bowels have moved involuntarily.

Examination revealed a fracture of the tenth dorsal vertebra, with considerable deformity and motion at the point of fracture. There was complete loss of sensation and power of motion below the level of the umbilicus. The displacement could, in a great measure, be reduced by traction and manipulation, and on the third day after admission, and the seventeenth after the accident, she was partially suspended and a plaster cast applied. Five days later the cast was removed on account of the bitter complaints of the patient, and she was placed on an inclined plane at an angle of 35°, with extension from the upper half of the body by straps of moleskin plaster. By means of sand bags the body was fairly immobilized, and extension in the dorsal decubitus reduced the deformity satisfactorily. She was kept in this position till November 10th—about two months—when she was placed in the horizontal position. During this time a decubitus occurred in the lower lumbar and sacral region, and at several places along the legs, in spite of all precautions used. The only improvement noted was that the line of anesthesia was lowered to the level of the pubes, and that no appreciable motion existed at the seat of fracture. The decubitus in the lumbar region was cicatrizing—patient's nutrition was good, and pain not a prominent feature. Defecatation and urination were still involuntary. It was decided to examine the cord at the seat of injury and to relieve whatever compression existed.

On the 17th of November, under ether, an incision was made from the spine of the fifth to that of the twelfth dorsal vertebra, and the spines of the seventh, eighth, ninth, tenth, and eleventh vertebræ cut off and the cord exposed in the manner already described. It was found that the body of the tenth vertebra had been broken, and that a large mass with a sharp edge encroached on the canal from in front for more than half its diameter. The dura was accidentally incised and immediately sutured with pure catgut. The cord itself was not examined. The adhesions between the dura and the canal walls were broken with a probe, the cord lifted as far as the spinal nerves would permit and an effort made to recover a portion of the projection on the anterior wall, but without success. The posterior wall opposite the projection was thoroughly removed, and for some distance above and below relieving all counter pressure. The wound was closed with deep and superficial sutures and sealed with iodoform collodion. The patient was placed in bed in the ventral decubitus, and rallied well from the operation.

The wound healed by first intention, and the stitches were removed on the eighth day. The prone position was maintained during this time, and at the close of it the line of the spines was almost perfect. Owing to her complaints it was then changed to the supine, as a result of which there was some lateral displacement of the lower two spines, the lower of which gave her a great deal of pain, though it did not overlie the exposed portion of the cord. Two months after the operation she menstruated for the first time since the accident, and could tell when deep pressure was made over the malleoli or tibiæ, though otherwise her condition was less changed by the procedure. For the last few months she has been gradually failing, and she will probably die before many weeks.

CASE II.—Thomas S——, æt. 34; ship carpenter; admitted November 21, 1893. Temperature, 100° F.; pulse, 80; respiration, 24. Twelve days ago he had fallen a distance of 20 feet, striking on his back. He did not lose consciousness, nor did he suffer much pain, but felt numb and was unable to rise. He was put to bed, and has since been unable to move his legs or void his urine. The bowels have moved but once, that being four days ago.

Examination revealed a fracture of the spine at the eighth or ninth dorsal vertebra, with considerable deformity and mobility. Complete paralysis of both lower limbs and anesthesia of both legs and the lower third of both thighs was present, and there was also a large decubitus over the sacrum. Patient was placed at once on an inclined plane at an angle of 15°, and 15 pounds of extension applied to the legs, without reduction of the deformity. This position was maintained for 30 days without any change in the symptoms. He complained at times of considerable pain in the right side, but otherwise made no complaint; ate and slept well, and the bed-sore improved rapidly.

It was decided to examine the seat of fracture, and on the 20th of

December an incision was made and a laminectomy done, involving the sixth to the tenth dorsal vertebra. A fracture of the ninth vertebra was found, with compression of the cord. All points of counter pressure being removed, the dura was incised. The cord was edematous, and old extravasations of blood were noted, but its continuity was not destroyed. The incision in the dura was united with fine catgut, and the wound closed as in the previous case. Nine days after the operation the stitches were removed, the wound having healed by first intention. The day after the operation the temperature was 101° F., but it fell to nearly normal the following day, remaining between 99° and 100°, till the twenty-seventh, when it rose to 102.5°, and thereafter fever was more or less severe.

Two weeks after the operation patient could tell when his toes were touched, and slight motion was noticeable when he tried to move them. Two weeks later his condition was about the same, but pain in the right side gave him considerable trouble; he was not eating so well, and sleep was more or less disturbed by a dry cough. Dulness was noted in the left apex, which rapidly spread till the whole left side was involved. Ten days later he began to expectorate a good deal, the sputum being muco-purulent and streaked with blood, but repeated examinations failed to reveal tubercle bacilli. From this time patient rapidly failed, and he died on February 16, 1894.

Post-mortem examination showed the left lung completely solidified, with small tubercles, only one very small cavity being discovered in the apex. The right lung was more or less studded with tubercle, other viscera normal. The body of the eighth vertebra had been driven into that of the ninth, crushing it and crowding the fragments forward and back till its anterior edge almost touched the body of the tenth vertebra, which with the eighth were intact. Remarkably firm fibrous union had taken place, and removal of the posterior wall of the canal had, apparently, sufficiently removed the pressure on the cord occasioned by the protrusion from the anterior wall of the crushed body of the ninth vertebra. The improvement in sensation and motion, though slight, was enough to encourage the belief that it would have continued, had not acute pneumonic phthisis supervened and carried off the patient.

CASE III.—Edward D——, æt. 26, colored, laborer; admitted January 11, 1894. Ten months ago was struck in the chest by a log, but was not prevented from working by the accident. Shortly after began to suffer sharp pain in the region of the fifth dorsal vertebra, which has been more or less constant since. About two months ago he noticed a lump appearing in this region. Had had a chancre, followed by secondary symptoms, two years ago; was treated for four months for same. About six weeks ago noticed that he was losing control of the lower limbs and that sensation in them was also impaired. The case came under the care of Dr. W. L. Adams, who put him on heavy doses of iodide of potash and a course of electricity. The symptoms rapidly increased, till he was unable to work and could scarcely walk. The case was then diagnosed as Potts' disease, and was referred to Dr. Hirschfelder, who concurred in the diagnosis of dorsal Potts' disease, with pus or a sequestrum pressing on the cord, and advised operation.

He was sent for this purpose to the City and County Hospital, where examination revealed a lesion at the fifth dorsal vertebra, the spinous process of which was very prominent, deviated to the right, and painful on percussion. There was marked anesthesia from the level of the tenth rib down, considerable atrophy and paresis of both lower limbs. Gait spastic and walking difficult; did not reel much when the eyes closed. Lungs and heart apparently normal.

On January 15th, under ether, laminectomy, involving the spines of fourth, fifth, sixth and seventh dorsal vertebræ, was performed. An abscess containing an ounce of cheesy pus was found under and around the transverse process, on the right side of the fifth vertebra. It communicated with another cavity of about equal size between the pleura and the head of the ribs, and also with the spinal canal, in which was a sequestrum ¾ in. long, ½ in. wide and ⅛ in. thick. The sequestrum was removed. The walls of the cavity were thoroughly scraped, as was the involved transverse process. No involvment of the body of the vertebra could be discovered. The dura was also scraped, as it was involved, but was not opened. Owing to the difficulty of reaching the intra-thoracic portion of the abscess through the original opening, a second incision was made four inches to the right of it, and the cavity entered, cleansed and packed with gauze. The original wound was thoroughly irrigated, and, as in the previous cases, closed without drainage and a plaster jacket applied.

January 24th the cast was taken off and the stitches removed from the primary incision, which had healed by first intention. The iodoform gauze packing was removed from the second incision, and, after filling the wound with glycerine-iodoform emulsion, it was repacked. Owing to the formation of a decubitus over the sacrum, the cast was not renewed. February 20th a rise of temperature occurred, and an accumulation of pus was found near the lower part of the open wound, which was drained. The iodoform emulsion was continued and the wound enlarged several times, as its contraction required; but a sinus still exists.

The anesthesia was somewhat lessened after the operation and the general condition much improved for a time, but pulmonary tuberculosis rapidly supervened, and the patient is gradually succumbing to it. There is a small sinus leading to the site of the intra-thoracic portion of the disease, but the discharge from it is very slight.

The original lesion in the spine seems to have been completely cured by the operation, and the rapidly increasing symptoms of pressure on the cord, which were the indications for operation, were at once arrested by it. Firm fibrous union occurred, and but slight deformity is present at the seat of operation.

229 Geary street.

PUERPERAL MANIA.

By B. M. GILL, M.D., Dunsmuir, Cal.

Read before the California Northern District Medical Society.

Osler says: "We do not all start in life with the same amount of nerve capital. Parents who have been the subjects of nervous complaints or of mental troubles transmit to their children an organization which is defective in what, for want of a better term, we must call nerve force. Such individuals start handicapped, and furnish a considerable proportion of our neurasthenic patients. So long as they are content to transact a moderate business with their life capital, all may go well, but there is no reserve, and in the emergencies which constantly arise in the exigencies of modern life, these small capitalists go under, and come to us as bankrupts." I might add, the same law will include nearly all cases of puerperal mania.

It is the purpose of this paper to treat mostly of those cases of mania, and the conditions antecedent thereto, which occur shortly after confinement. In the hurry and bustle of active practice, many medical men do not, in the absence of skilled nurses, take time to order in detail every arrangement necessary to insure that perfect quiet and rest which is absolutely required after such an important event in the life of a young, and often very nervous, mother. It is true there are cases that possess such a strong and well-balanced nervous organization as to be perfectly free from any possible accident. It is not unlikely that family history has often much to do with the case. Heredity will frequently manifest itself in a very astonishing manner. Every practitioner of much experience can recall cases where, probably, had he not taken the case in hand in a very vigorous manner, it would have resulted in something serious in a few hours, or in a day or two, at least. In my own practice I have had but three cases that came anywhere near a full-fledged mania. I have seen several in the practice of others, notably so-called midwives, that were extremely serious.

Every practitioner can easily understand that the condition of pregnancy is not always physiological, but in many cases quite pathological. The action on the nervous system from reflex causes; the continuous suffering from disorders of digestion; imperfect action of the kidneys; loss of sleep, as well as a hundred other correctable symptoms to which the mother is subject, and which she is often told that she must bear, as they belong to her condition and cannot be helped, are some of the causes which lead up to that deplorable affection, puerperal mania.

It is no wonder that we often find women of sensitive nervous organization suffering from hypochondria and great anxiety as to the outcome of their confinement, which is no wise abated by the stories of garrulous neighbors as to what a hard time they had, as well as many others in their extensive acquaintance. How much better that the young mother should frequently see and consult with her family physician, who would encourage and advise her as to what is best, rather than listen to foolish gossip of indiscreet people.

It is well, also, that the physician should know that pregnancy influences a woman's susceptibility to some diseases and produces greater immunity from others. The great lack of uniformity of effects caused by pregnancy is no more than we might expect when we remember what a great variety of organizations we have to deal with. To recapitulate, while pregnant women are more protected from attacks of epidemic diseases, they are much more liable to nervous derangements, from the fact that the blood is more deficient in red blood corpuscles than the average in a non-pregnant woman, thus reversing the idea that pregnancy causes plethora. Yet, there are many exceptions to this rule. While chronic diseases, such as heart or lung troubles, may be held in abeyance, inflammatory diseases, as hepatitis, nephritis, enteritis, peritonitis, dysentery, etc., are among the possibilities; yet those conditions which provoke grave nervous disturbances should ever keep the careful and conscientious physician on the alert.

Many of the causes which lead up to other forms of insanity do not obtain in this form. While we may all agree that it is very possible there may be many common conditions, such as heredity, or an acquired weak nervous organization, yet puerperal mania has something peculiarly distinctive about it. The afflicted one is usually harmless. A tendency to suicide or homicide seldom exists, while great timidity and fear are nearly always present. Loss of sleep is a prime factor in causation, as I believe this "nature's restorer" is the all important *desideratum* to be obtained, if any favorable progress is to be made. In discussing any possible pathological changes, I can only say that poverty of blood and albuminuria are often accompanying conditions. In fact, it is the great essential in the treatment of this malady to insure sufficient good sleep. There is no insomnia that we encounter that is so obstinate, so determined, and so hard to overcome. I believe that if we could trace back every case, we should find the patient losing hours of sleep every night. I have often heard ladies say that the motion of the child was so strong as to disturb sleep, while anxiety as to the outcome, a hundred aches and pains, added to all the other causes, had led up to the same result. In plethoric persons it may be due to cerebral congestion, but in by far the greater number of cases it is caused by the exhaustion of the nerve centers, and general irritable state of the system consequent thereon. The prognosis in these cases, under proper care in private practice, is in a large per cent. favorable, and it may be said, I think, with much truth, that in the unfavorable cases heredity has a large influence.

While many rely on chloral hydrate, bromides, sulphonal, etc., my own experience leads to a preference for somnal as a drug. There is great danger of overdoing all drugs, and of establishing habits more or less hard to break up. Some years ago I had a case that seemed to baffle all remedies and methods. The patient had drifted into a condition of idiotic melancholia. One moment she would laugh, the next cry, or again sit for hours in a half stupid state. She had improved in a general way; could walk about, ride in the open air several miles without much fatigue, but the mental condition was constantly growing worse. As an experiment, I suggested to her husband that he take her to a stream a few miles distant, where the fishing was good, and spend a few weeks or more fishing, directing him to pay all attention to her, adjusting the fly or bait, taking off the fish, and have no other subject on hand from morning till night but fishing; thus diverting her mind, and getting her thoroughly tired out. The result was, in two days' time she slept well all night and after two weeks she was quite herself. Continued change of scene resulted in a permanent cure.

Some cases are much benefited by stimulants, yet the responsibility of the physician is again put to a test, knowing that he is placing a temptation before a weak person. So that in the choice of remedies for this very important symptom, the medical man must again be a man of sound judgment and discretion.

Next in order of treatment is the quantity and quality of food. In bad cases it is hard to have much food taken. You are anxious to secure an early return of the diminished or lost milk secretion. And here let me add, in parenthesis, that no more reprehensible thing can be done than to try to hurriedly dry up the milk in case of the death of the child. I have heard of the application of camphor, belladonna, and other agents to assist in diminishing the secretion, and this even while the patient is yet confined to the bed, all of which I think should not be recommended, more especially in the cases of extremely nervous persons. There are cases where there has been such a great loss of blood, and depletion, as to make it desirable to dry up the milk. In these, nature, as a rule, does the work unaided. The bad cases will not eat, or drink, and before you know it you are at your wits' ends. Nourishing enemata will, as a rule, not be retained, while the end to be desired is rapidly vanishing. As a *dernier resort*, rather than further jeopardise my patient, I think I would forcibly put a liquid food into the stomach. Good milk and eggs, thoroughly incorporated; buttermilk (if the mother is not nursing); mutton soup; a generous beef tea, with some farinaceous thickening, would seem very appropriate for this method of feeding.

Hypnotic influences will undoubtedly do much good if applied intelligently. To sum up: many of the indications for treatment of the cases that cannot be aborted (and, I believe, many cases can be by prompt efforts), are to subdue all exhausting discharges, use all reasonable means to keep up the strength, and over and above all, have absolute conditions of quiet. All the natural excretory functions should be carefully watched, and, in short, every thing which the eagle eye of the ever watchful physician may detect that would in any way add to the nervous condition, even if it involves the temporary removal of the nearest relatives, if they do not exercise sufficient good sense to restrain their emotions and obey orders. The responsibility is great, and no man should court it unless he can have the best possible coöperation, and, if obtainable, trained nurses.

A CASE OF EXTENSIVE LACERATION OF THE PELVIC FLOOR OF FIFTEEN YEARS' STANDING, SEVERING THE SPHINCTER.—THREE UNSUCCESSFUL ATTEMPTS AT UNION.—ULTIMATE SUCCESS WITH RETENTIO ALVI.

By O. H. Hund, M.D., San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

The patient, Mrs. C. D——, was delivered of her first child March 28, 1879. She was at that time 27 years old. It was a cross-presentation and the labor was tedious, the child dying during delivery. She made a very slow recovery, owing to extensive injury to the floor of the pelvis. She was afterward examined by a gynecologist of this city, who advised an operation; but while preparing for it she became pregnant, necessitating a postponement. Her second labor, like the first, was tedious, owing to cross-presentation, and the child died during delivery.

As soon as time would permit, an operation was performed with negative results. One year following she became pregnant. This was followed again by tedious labor, cross-presentation and death of the child during delivery. After this third labor she was operated on with the same poor results. Her general condition in the meantime was constantly getting worse; she had lost all control of the sphincter, and there was a constant muco-fecal discharge from her bowels. Nevertheless she kept on getting pregnant again and again, five times more, being eight times altogether. These five labors all had the same history—cross-presentation and tedious labor, the children dying during delivery. Fifteen months after the fifth accouchment she underwent her third operation, but it did not prove successful in uniting the tissues.

In May, 1893, one year after the last confinement, I saw her for the first time. She was then over 40 years of age, in very poor health, and suffering a great deal of pain about the region of the injury. She had no control whatever of the anal sphincter. When there was constipation she had but little trouble; but when the bowels were loose and when there was flatulency, she suffered a good deal.

On examination, I found that the laceration involved the sphincter ani muscle, and extended upward into the wall of the rectum and of the vagina, clear to the cervix. The muscles of the pelvic floor, except the transversus perinei and sphincter ani acted fairly, holding the two severed portions well up. The ruptured ends of the sphincter were drawn outward and backward by the retraction of the muscle. The cervix was badly lacerated and considerably enlarged, while there existed cystic degeneration of its mucous membrane.

She was first treated locally for about three months; then Emmet's operation was performed successfully, and at last, six weeks later, the day was set for an attempt to rectify the extensive lacerations present and to restore as nearly as possible to their normal conditions the vagina and rectum.

On July 29, 1893, with the kind assistance of Drs. R. L. Rigdon and Wm. J. Hawkins, the patient was fully anesthetized and placed in the lithotomy position. A Sims' speculum was introduced superiorly and the anterior vaginal wall elevated. The tissues on each side of the laceration were vivified well out on the vagina within an inch of the lower side of the vestibule, so as to obtain a broad surface for coaptation. Only enough of the mucous membrane of the rectum was removed to dispose of the cicatricial tissue present. Catgut sutures were now introduced from above downward, about one-twelfth of an inch apart, and tied on the rectal side. Each one was tied as soon as introduced, there being altogether thirty-six stitches through the rectum. Ten silk sutures were introduced through the vagina from the outer edge of the vivified vaginal mucous membrane, carried deep into the tissues, emerging a little within the edges of the rectal mucous membrane, and tied upon the vaginal side of the new-formed septum. The perineal stitches, six in number, were placed last. Iodoform was dusted on the wound and it was covered lightly with iodoform gauze.

The patient was then placed in bed and the thighs tied together. For thirty-six hours before the operation and during nine days following liquid food only was given. There was no pain to speak of after the operation, opiates not being required. The urine was drawn twice during the twenty-four hours for twelve days. On the third day she suffered from flatulency, which was relieved by the introduction of a catheter into the rectum. On the tenth day she began taking a powder containing two grains of calomel, five of rhubarb and ten of bicarbonate of soda every five hours until the bowels moved, which took place on the twelfth day. The stitches were removed on the fourteenth day, but she was kept in bed for another week. Every third day (after the twelfth) until the twenty-fourth her bowels were moved by a dose of castor oil.

On the twenty-fifth day she was allowed to get up, the wound having been carefully examined and union found to be perfect throughout. The function of all the muscles of the pelvic floor was restored and the patient was discharged from treatment with complete retaining power of the sphincter ani.

716 Howard street.

INFANTILE SPINAL PARALYSIS: A STUDY OF ITS ETIOLOGY.

By Frank Fischer, M.D., San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

There is little room for difference of opinion upon the pathological anatomy of infantile spinal paralysis. There are still a few authorities, who, like Vogel,[1] claim that the usually recognized pathology has not been conclusively demonstrated. But the clinical picture of the disease is quite concordant with an inflammation and a subsequent atrophy of the anterior gray horns of the spinal cord, and is equally discordant with any other supposed pathology. Hence, though the lesion had not been demonstrated in many necropsies, the inference as to its existence would be sufficiently logical to warrant its acceptance.

Although the pathology of the trouble offers little ground for contention, the etiology is still a matter of dispute. "Little is known," says Hammond,[2] "of the etiology of infantile spinal paralysis;" and he adds that in the great majority of cases that he has witnessed, no cause could reasonably be assigned. Another author[3] remarks: "We know little or nothing as to the causes which produce the disease." Such being the case, it will be worth while to investigate, upon this point, the histories of patients who have suffered from this trouble. The etiology of any disease is a branch of medical study upon which it is impossible to lay too much emphasis. Prophylaxis is the medicine of the future. Logical prophylaxis must be based upon a knowledge of the causes of disease, upon a provident anticipation of those causes, and upon appropriate precautions for averting their effects. Thus, the discovery of the true cause of a malady is half the cure. These reasons will, therefore, serve as sufficient justification for limiting the present paper to a discussion of the etiology of poliomyelitis anterior acuta.

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[1] A Practical Treatise on the Diseases of Children, p. 327.

[2] Diseases of the Nervous System, p. 327.

[3] Henry W. Berg in Reference Handbook of the Medical Sciences.

In a recent number of the *American Journal of Obstetrics*, Dr. Anna Galbraith discusses this subject of causation upon the basis of a large number of cases that had come under her observation. Having had access to the records of 36 cases[1] of this disease, I have in the following pages analyzed them upon lines similar to those pursued in the paper referred to.

The causes are divided into predisposing and exciting. In the former are included: Sex; age; season of the year; climate; race; condition of health; heredity, and tuberculosis or tubercular diathesis.

The exciting cause may be anyone of the following: The psychical; the exanthemata; acute febrile diseases; exposure to cold; over-exertion; traumatism; dentition, and infection.

Sex.—Boys are more frequently attacked than girls. Of the 36 patients with whose histories we are dealing, 20 were male and 16 female—a proportion of 5 to 4. This difference in frequency of occurrence in the sexes is not so great as has been found by some authors. Galbraith's cases give a ratio of 5 to 3. This preponderance of the male cases is probably not accidental. Although many of the more recent authors do not speak of the fact, or imply that the disease is equally frequent in both sexes, there is no author that finds a preponderance in the other direction. The ratios given range from 5 boys to 3 girls to 10 boys to 9 girls; the latter being the results derived from Sinkler's figures[2].

Age is, beyond doubt, a predisposing element of infantile paralysis. It is a disorder almost exclusively of infancy. Gowers states that three-fifths of the cases occur in the first two years of life, and four-fifths in the first three years; and these results represent about the average of those obtained by other writers on the subject.

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[1] Recorded at the Neurological Clinic of Cooper Medical College.

[2] Keating's Cyclopedia of the Diseases of Children, Vol. IV, p. 685.

The ages in our cases are as follows: At 3 months, 1; 9 months, 3; 11 months, 2; 12 months, 2; 15 months, 1; 17 months, 1; 18 months, 2; 20 months, 4; 21 months, 1; 22 months, 1; 24 months, 4; 27 months, 1; 36 months, 3; 37 months, 1; 43 months, 1; 46 months, 1; 47 months, 1; 50 months, 1; 54 months, 1.

It will thus be seen that the youngest of our cases was 3 months old, and that the eldest was aged 4½ years. Of the entire 33 cases, 8 therefore occurred in the first year, 15 in the second, 4 in third, 4 in the fourth, and 2 in the fifth. The curve of relative frequency thus attains its greatest hight in the second year, and then suddenly falls. During the first two years 22 of the 33 cases (66 per cent.) are found to have occurred; and during the first three years 26, or about 80 per cent. This agrees fairly well with Gowers' figures, and it is clearly evident that age predisposes to the disease.

Is there, then, any reason to suppose that the anterior horns of gray matter in the spinal cord are more sensitive during infancy than in adult life? This question would doubtless be answered in the negative, yet it will be readily acknowledged that the entire nervous system of the child is far more susceptible to impression than is that of the adult. Irritants or excitants, that in the latter would be insufficient to provoke a reaction, are ample in the former. It is well known that in many acute diseases where, in adult life, a chill or general malaise will usher in the attack—in infancy, violent convulsions will often constitute the initial symptoms. Convulsions in infancy may also result from a variety of comparatively trivial causes, as the presence of worms in the intestines—causes such as would be insufficient to produce so violent an effect in later life. These facts may, by analogy, lead to the inference that the restriction of anterior poliomyelitis to infancy is attributable to the greater irritability or smaller power of resistance of the nervous system at that age.

There is another theory that may account for this early occurrence. Dentition is an influence of an irritative nature, to which the child is subject and from which the adult is exempt, tending to the production of a nervous disorder. "The first dentition," says J. Lewis Smith, "commences at the age of about 6 months, and terminates at the age of 2½ years." This, then, would be another factor to explain the occurrence of the disease almost exclusively in infancy.

The season of the year has a marked influence in predisposition. Strümpell, in his "Text-book of Medicine," says that most of the cases occur in warm weather. This association is well exhibited in the cases under consideration. There were: in January, 1 case;

February, 0; March, 2; April, 2; May, 3; June, 2; July, 2; August, 6; September, 5; October, 3; November, 2, December, 1. You will notice that the curve of greatest frequency occurs during the warmest months, August and September; that there is a comparatively regular and gradual rise to that point, and a similar, even more gradual and regular, fall from that point. During the months of July, August and September, in which the maximum was attained, the number of cases (13) constituted about 45 per cent. of all the cases; while during the warmer half of the year over 72 per cent. of the cases are found. In Keating's Cyclopedia of the Diseases of Children, it is noted that 79 per cent. of cases occurred in the hot months. Gowers also states that of his cases, two-thirds were attacked between June and September.

Climate.—The difference in frequency of occurrence in various localities suggests its own explanation. Probably our cases do not exhibit this tendency so remarkably, because our climate does not represent such extremes of heat and cold. Heat acts simply as a prostrating influence, weakening the resistance of the individual. It is probably not the absolute degree of heat that determines the occurrence of the disease, so much as the greatness of the range of temperature in the given locality.

Race has no decided influence that can be clearly demonstrated. There are nervous diseases from which certain races are peculiarly exempt. Wharton Sinkler, in Keating's "Cyclopedia," speaks of the remarkable immunity of the colored race from chorea. Similarly, there are nations that are peculiarly subject to certain diseases. Thus, neurasthenia has been described as the American disease, *par excellence.* No such relationship, however, can in the present case be traced between race and exemption from, or susceptibility to, this malady. Of the 36 cases, 22 were born in California, 1 in Missouri, 2 in Nevada, 1 in Oregon, and 5 in other States. There were, also, 1 born in Australia, 1 in England, 2 in Germany, and 1 in Italy. The nationality of the parents was not recorded in the histories. Galbraith found that, while no race was exempt, those of German parentage seemed more prone to the disease than others. This, however, may have been a coincidence in that particular collection of cases.

Condition of Health.—We are prone to imagine that those in good health are least liable to most diseases.

In the present case, poor health does not appear to predispose to attack. For, as Strümpell has said, "the children are almost all perfectly healthy previously." He goes even further, and declares that the patients "come of healthy families without any neuropathic predisposition." Among our cases there were but seven whose previous health is recorded as poor. Of these, two had rachitis, in one case associated with microcephalus. Of the remaining five, two had been troubled previously with diarrhea, one with general digestive disturbances, one with anal fistula, and one with scrofula. The large majority, however, had previously enjoyed good health.

In a number of cases the attack was coincident with other troubles; in one with cough and a slightly sanguinolent diarrhea, in one with epistaxis and bronchitis, in three with vomiting, in one with simple diarrhea, and in one with bronchitis alone. In this record there is no trouble sufficiently uniformly associated to warrant the assumption of a causal relationship. Nor is there any disease or dyscrasia present in a sufficiently large percentage of the cases to justify the conclusion that poor health *per se* is a predisposing element. While this is the conclusion arrived at by most authors, Galbraith finds poor health in 44 per cent. of the cases.

Heredity.—Haycroft, in an article in the *Lancet*, on "Darwinism and Race Progress," quotes Dr. Bastian as follows: "It is now a well-established fact that persons who are endowed with a neurotic habit of body very frequently transmit a similar tendency to their children. It is not a tendency to any particular nervous disease, but a vulnerability of the nervous system as a whole which is transmitted, so that under the influence of even a comparatively slight strain, the weakness may manifest itself in one or other of several ways." The truth of these propositions in general cannot be denied. But in the case of infantile paralysis, the facts confirm the verdict of Strümpell, that "the children come of healthy families *without* any neuropathic predisposition." In our list there are but twelve in which I find the family histories recorded; but in only one of that number was there anything that could be construed as a neurotic family history. In this case the great-grandfather and the grandmother had died of cerebral apoplexy; the latter having also had an attack of chorea during childhood.

Tuberculosis.—The suggestion of this element as a possible factor in producing the disease is entirely original with Galbraith, and is based solely upon her own observations. She says: "On entering upon duty in the neurological department of the New York Orthopedic Dispensary, three years ago, with little more than a theoretical knowledge of poliomyelitis anterior, the first thing to strike my attention, contrary to all that the text-books taught, was the profound anemia of the little patients, accompanied in many cases with well-marked emaciation, a tendency to bronchitis, enlarged submaxillary and cervical glands, and the most obstinate eczema. Again, I was surprised by the frequency with which phthisis and other lung affections were noted." She found that in 18 per cent. of the cases there was a family history of pulmonary tuberculosis, while in 28 per cent. there was a history either of that or of some other form of tubercular disease. Among the patients themselves, she found some marks of scrofulosis, and in some a susceptibility to inflammation of the respiratory tract. Whether these manifestations were sufficiently frequent to establish a causal relation is open to argument. The fact that 12 out of 62 cases were subject to inflammations of the respiratory tract does not seem to indicate a very marked prevalence of tubercular trouble. However, the author's argument is not that tuberculosis in the patient himself predisposes to the disease, so much as that the inherited tubercular diathesis has a tendency in this direction. In one of our own cases the mother had died of phthisis. Of the children themselves, two exhibited enlargement of the cervical glands, and one had an anal fistula at the age of six weeks.

We now come to the exciting causes of infantile paralysis. The first, as given by Dr. Galbraith, is the *psychical.* By this is meant a severe shock to the nervous system. The implication is that the previous psychical condition has rendered the child peculiarly susceptible to attack. As an example, the author cites the case of a patient, two years of age, who was perfectly well until the 4th of July, when she was startled by the firing of a cannon in the neighborhood. She gave a sharp, piercing scream, and was nervous and feverish for the next two days. During the second day she dragged the left leg, and then followed the other characteristic symptoms. Dr. Galbraith says: "The exciting cause was evidently psychical, the shock being caused by the unexpected and tremendous noise." Among our own cases there were none that exemplify this cause, unless those in which a fall preceded the attack can be so construed. In such cases, however, it is difficult to decide how much to ascribe to the physical injury, and how much to the accompanying mental shock.

The Exanthemata.—It is a well-known fact that, after an attack of one of the exanthemata, a characteristic peripheral paralysis is not uncommon. It does not appear beyond the pale of possibility that the same product of retrograde tissue metamorphosis, or of germ life, instrumental in producing the paralysis in these cases, may also be concerned in the production of poliomyelitis. In the paralyses following diphtheria, or in those seen in influenza epidemics, the specific infectious material has, by its irritation, probably produced a peripheral neuritis. In infantile paralysis we have only to suppose that this same material has found a more central lodgment and caused a like irritation in the neighborhood of the anterior gray horns of the cord.

In our own cases there was but one instance in which the disease followed an exanthem. This was in a child of 3 years and 1 month, convalescing from an attack of measles, beginning five weeks before the commencement of the second trouble. In another child, aged 9 months, the eruption of measles appeared one week *after* the paralysis. Strümpell is skeptical of any such relationship. He says: "The paralyses arising after acute diseases like measles, scarlet fever, small-pox, etc., are perhaps partly of spinal origin, but they cannot be identified with idiopathic spinal paralysis of children." [1] Vogel, who describes the disease under the rather obsolete designation of essential paralysis, says: "In exceptional cases, essential paralysis of the lower extremities follows chorea, typhus fever, and the acute exanthemata. In these latter cases it develops most markedly during convalescence."[2]

Infantile paralysis is sometimes similarly associated with other acute febrile diseases, and in two cases I have noted that it followed or was coincident with an attack of acute bronchitis.

Exposure to cold has been enlisted as one of the exciting causes. In our histories there is no record of such association. Three of Galbraith's cases followed exposure to cold, and in one other case also there was a possibility of this having occurred. This is a very small percentage—hardly sufficient to warrant the predication of an intimate connection.

Over-exertion has been designated an exciting cause. The chief arguments in support of this view are that the age of most frequent occurrence is also that at which the children are beginning to walk, and that the lesion appears to occur much more frequently in the lumbar than in the cervical region. It is argued that the great functional activity of the lumbar ganglia, at the time when walking is begun, predisposes to an inflammation of those ganglia. In 91 per cent. of our cases the paralysis involved one or both of the lower extremities, while the upper extremities were implicated in but 40 per cent. Galbraith's figures are much more significant. In 100 per cent. a lower extremity was involved, every one of her cases having exhibited this feature, while in only 13 per cent. were the upper extremities affected. Another argument in favor of over-exertion as an exciting cause is that in several reported instances the paralysis has followed the taking of a long walk. Sinkler records one case in which the disease occurred after a continuous walk of five hours.

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[1] Text-book of Medicine, p. 629.

[2] A Practical Treatise on the Diseases of Children, p. 327.

Traumatism is the exciting cause to which three of our cases were ascribed. The first was in a child, 9 months of age, who had fallen, with her high-chair, two weeks before the discovery of the paralysis. This attack was also coincident with difficult dentition. In another case, the patient, aged 4½ years, fell from a wagon. Here the paralysis made its appearance immediately after the fall. The third case was a child of 4 years and 11 months, who had fallen down a small flight of stairs the day before the onset of the trouble. Galbraith reports 7 cases out of 64 as due to traumatism, 5 being the sequels of a fall, one following a violent fight, and the seventh occurring after the child had been thrown to the ground by a bicycle in rapid motion. If the traumatism be supposed to produce the ensuing trouble by its physical, rather than its psychical, effects, we must assume that it produces a concussion of the spinal cord.

Dentition.—All authors are unanimous in ascribing to dentition some relation to the present malady. The following facts render it more than probable that this process is an exciting cause of the disease. The ages of the patients correspond, on the average, to the period during which the eruption of the teeth occurs; the average age of most frequent occurrence of infantile paralysis is also the age at which the troubles of dentition are at their highest; the first dentition is associated with many other nervous manifestations in childhood. Another observation that serves to strengthen this conviction is that the dentition is almost invariably difficult in those cases that are attacked by poliomyelitis. There was but one case in our list in which it was positively claimed that the eruption of the teeth had been easy.

We have now reviewed all but one of the many factors that have, by various authorities, been supposed to contribute to the production of this disorder. The inference to be justly drawn from the observations recorded is, that infantile paralysis is either a disease due to a great variety of dissimilar and often apparently trivial causes, or that there is still another cause to which all cases can be ascribed, and to whose action these other factors are simply favoring circumstances.

Infection.—The entire clinical picture of the disease, as Strümpell has well pointed out, distinctly reminds the observer of the acute infectious diseases. We have here a trouble that occurs suddenly, for the most part in those previously in good health, and, as in many of the infectious diseases, there appears to be a particular time of year at which the disorder is most frequent. The attack is attended at its inception by a comparatively high fever. Finally, as in all the infectious diseases, there appears to be at first a general infection of the entire body, followed by a localized expression of that infection. Theoretically, infection would thus be an adequate explanation of the various phenomena of this disorder. There are, however, certain objections that must be satisfactorily met.

It will be asked, why, if this be a disease of infectious origin, is the lesion which it produces so strictly localized to one particular portion of the nervous system? In answer to this may be cited the somewhat analogous phenomenon that is exhibited in the peculiar selective influence possessed by certain drugs, sometimes one organ alone being affected. A still more striking analogy is the localized lesion found in certain infectious diseases. In typhoid fever, the agent of infection selects Peyers' patches and the solitary glands as the particular field of its activity. Pneumonia, which is now known to be a general infection of the system, finds a local expression in the lungs only. In diphtheria, the membranous deposit is confined to the upper respiratory and to the pharyngeal membranes, and we might multiply analogies by running through the entire gamut of recognized infectious diseases.

If infantile paralysis be an infectious disease, it is no more strange that its lesion should be confined to the anterior gray horns of the spinal cord than that there should be a similarly localized pathology in other infectious diseases. It is also probable that, just as in the infectious diseases, so here the lesion is at times not strictly confined to its usual site. The characteristic typhoid lesions occasionally appear on the tonsils and in other situations in the gastro-intestinal tract. In pneumonia the pericardium, the pleura, and the meninges of the brain may be invaded by the agent of infection, while the local manifestation in the lungs may be scarcely demonstrable. In diphtheria we may have a membranous deposit on the gastric or intestinal mucous membrane, on that of the genito-urinary tract, and even on abrasions of the skin. In infantile paralysis, it is therefore possible that there is not always an exclusive inflammation of the anterior gray horns of the cord.

At a recent meeting of the Vienna Medical Club [1]Dr. Redlich reported the results of an examination of the spinal cord in a 5-months old child that had died from acute anterior poliomyelitis. The lesion was not confined to the cord, but there were also observed small areas of inflammation in the medulla and in the cerebrum. "The phrenic nerve also showed spots of softening. The pathological changes would therefore point to an infectious process as causative of the disease; as a result of such an infection," says the writer, "the lesion may be in several locations, even involving the nerves, producing a multiple neuritis, a condition sometimes found associated with anterior poliomyelitis." The first objection, then, to the theory of infection would seem to have no force.

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[1] Medical Record, March 17, 1894.

A second objection that demands consideration is: If poliomyelitis is an infectious disease, why do we not occasionally hear of epidemics of the trouble? This may be met by the supposition that the agent of infection is not easily communicable; that it needs a peculiar soil for successful implantation, and that one of the most important of the favoring factors is the age of the child. This last fact would account for the escape of other children in the same family when one is attacked by the disease. When, however, there are twins in the family, this argument would not hold; and it is a fact that several cases have been reported where twins have had the disease at the same time. Occasionally we read such a statement, as the following, from the *Medical Record* of December 2, 1893: "Boston physicians find that acute poliomyelitis (infantile paralysis) was unusually prevalent during the past summer and fall." What explanation is so probable as that the disease is infectious in its origin?

At least one well-defined epidemic of the disease has been recorded. This occurred during the months of June and July, 1885, but was first reported by Cordier in the *Lyon Médical*, in 1888. There are some authorities that are inclined to view this epidemic with scepticism, and to doubt the correctness of the diagnosis. I have not had access to the original paper; but, from the perusal of several abstracts of it, there can be no doubt as to the identity of the disease, as far as the clinical picture is concerned. Cordier states that he saw 13 cases of atrophic infantile paralysis in a district containing less than 1,500 inhabitants. The patients varied in age from 10 to 30 months, and were, almost all, previously in good health. The attack in each case began with fever without other premonitory symptoms. This was followed in time by paralysis in one or more of the extremities, and subsequently by atrophy of the limbs affected. It only remained to show its contagious character to demonstrate that it was due to infection. In proof of this, Cordier states that one child was attacked 36 hours after a visit to another already affected by the disease. In another instance, two children, a boy and his sister, were exposed, and the first symptoms of the disease made their appearance eight or ten hours later.

It may be argued that in the Cordier epidemic, and in that of Boston, the weather may have been remarkably propitious to the occurrence of the disease. Granting that such were the fact, there is no legitimate reason why the unusual frequency should, in the one case, have been observed only in Boston, and in the other only in the locality mentioned by Cordier.

In view of the evidence offerred, it is probable that infantile paralysis is of infectious origin. Decisive proof of this theory can be found only in the microörganism that produces the infection. Perhaps enough has been presented to compel a partial acquiescence in this conclusion. At least, instead of rejecting the theory, we are justified, while awaiting further evidence, in according it the Scotch verdict of "not proven."

906 Market street.

HOSPITAL REPORTS.

SAN FRANCISCO RECEIVING HOSPITAL.

UNDER THE CARE OF GEO. B. SOMERS, M.D.

Death from Impaction of the Large Bowel with Undigested Wheat.

On September 4, 1894, J. M. R—— was brought to the San Francisco Receiving Hospital, suffering from intense abdominal pain. He gave no history of his trouble except that he had been constipated for several days past. Sedatives were administered to relieve pain, hot applications made to abdomen, large enemata of soap and water given, and finally saline cathartics. The enema passed without result. In about eight hours after entrance, a profuse watery diarrhea began. Nothing curious was noted in the first passages, but a few hours later the steward reported that he had found a few grains of whole wheat and corn in the stools. From this time on the patient showed symptoms of collapse, and died 24 hours after admission. The Coroner was requested to have a *post-mortem* examination made, and through the kindness of Dr. Emerson, the Coroner's physician, the following points were noted: The patient was apparently about 45 years old, well nourished, and about 5 feet 8 inches in hight. Nothing of importance was discovered in any of the internal organs except in the abdominal cavity. Considerable peritoneal fluid, of a dark, brownish color, was noted. The colon, from cecum to sigmoid flexure, showed a gradually increasing congestion. About the sigmoid and rectum there were many fresh adhesions. On opening the colon, large masses of whole wheat were found within. In the sigmoid and rectum the wheat, mixed with fecal matter, was packed so firmly as to overdistend the bowel and lodge there. Collected and weighed, it amounted to about one and one-half pounds. No perforation of the bowel was noted. The teeth were in bad condition, and not capable of grinding. The patient, before death, did not give the slightest clue as to the cause of his trouble.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By Wallace A. Briggs, M.D., Sacramento, Cal., and
Henry Gibbons, Jr., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Non-operative Treatment of Fibroid Tumors.—Dr. Lutaud recommends the following remedies as efficacious in arresting the development of fibroid tumors and reducing the volume of the uterus. It is not always possible to operate at once upon these tumors, and in some cases it is not advisable to operate at all. Hydrastin is useful in hemorrhage and in the hypertrophied condition of the uterine tissues, which nearly always accompanies fibroids. He administers hydrastin, hypodermically, according to the following formula:

Hydrochlorate of hydrastin	cg. 50
Distilled water	gm. 10

Given daily by means of a Pravaz syringe. When subcutaneous injections are not well borne, we may use the tincture of hydrastis canadensis:

Tincture of hydrastis canadensis	gm. 4
Tincture of opium	gm. 30
Distilled water	gm. 150

Dose, one tablespoonful three times a day. Ergotin may also be given hypodermically:

Aqueous extract of ergot.	
Glycerin	āā gm. 2
Distilled water	gm. 10

Add a few drops of Van Swieten's liquid if the solution is to be kept a long time. Administer by a Pravaz syringe every two days. Whenever cardiac complications exist with great vascular distension, digitalis and iodide of potash should be associated with ergotin:

Syrup of digitalis	gm. 60
Iodide of potash	gm. 10
Syrup of orange peel	gm. 120
Ergotin	gm. 2

One tablespoonful morning and evening. Rye ergot may be administered internally if the patient prefers:

Pulverized rye ergot	gm. 5
Sulphuric acid	gm. 1
Distilled water	gm. 250

Boil, and evaporate to 100 grammes. Add—

Alcohol	gm. 10
Syrup of cinnamon	gm. 30

One tablespoonful every hour. Constipation nearly always accompanies large uterine fibroids. Pain and flatulence are frequent symptoms, due to inflammatory adhesions and false membranes. It is important to watch carefully the patient's diet, and to avoid dilatation of the stomach and intestines. Opiates are sometimes indicated, and sometimes laxatives. Tablets of magnesia and salol often relieve constipation, dilatation of the stomach and intestinal infection:

Calcined magnesia	gm. 15
Salol	cg. 0.50

In 15 tablets, one before each meal. In vomiting, or obstruction of the biliary passages, calomel is the preferable remedy, combined with opium for the purpose of preventing colic:

Calomel	gm. 1
Tincture of opium	cg. 0.5

Ten pills. One every morning and evening. Salt baths are nearly always beneficial in fibroid tumors, and patients are rendered more comfortable by wearing a fitted bandage made of light elastic material.—*Journal de Médicine de Paris*, July 29, 1894.

Treatment of Dysmenorrhea of the Cervix.—Women who have borne children are especially liable to dysmenorrhea caused by stricture of the cervical canal in the vicinity of the internal orifice. They generally suffer from cardialgia and cephalalgia of reflex origin, and during menstruation from severe pains resembling those of labor. Questioning will usually elicit an account of previous attacks of endometritis caused by labor abortion, or some morbid condition. Examination with a sound reveals a stricture on a level with, or immediately in front of, the internal orifice; the passage of the sound through the stricture causes severe pain. In 5 cases of this form of dysmenorrhea, DR. NOLL used applications of chloride of zinc, 50 per cent. of tincture of iodine and of perchloride of iron, with dilatation of the cervix with Hegar's sound No. 10, without attaining any permanent result. He then decided to perform the operation advised by Feilsch for internal stricture. After disinfection of the parts, he dilated the stricture with Hegar's bougie No. 9; and then, with a small bistoury, made radiating incisions in the contracted part, sponged it with sterilized gauze, and applied a Paquelin cautery, corresponding in size to the dilator No. 9. The dilated part of the canal was then tamponed with iodoform gauze, which was pushed into the uterine cavity. The patient should keep her bed for six days. This treatment effected an immediate and a permanent cure in every one of the five cases.—*Centralblatt f. Gynäkologie*, No. 231, 1894.

Dangers of Curettage.—During a recent discussion of this subject in the Obstetrical and Gynecological Society of Berlin, six cases were reported which show how dangerous this operation may be in certain conditions of the uterus. The principal danger is that of perforation; but it is not equally great in all cases. In metritis the uterine tissues are resistant, and afford a solid floor upon which the curette may be carefully moved backward and forward with slight risk of perforation. The uterus is in a very different condition after abortion or labor. The tissues are profoundly modified, and the thickness of the walls greatly diminished. The dimensions of the cavity are irregular, and there is danger, even with the greatest precautions, of penetrating the peritoneal cavity. The cases reported by the German surgeons were principally of this kind, and in several of them the wound was so large that a loop of the intestines entered the cavity of the uterus. These cases are instructive, as they show that this operation should not be undertaken lightly, even by skilful men. They demonstrate what we have long known, and what cannot be too often repeated, that the uterus in involution is ruptured with the greatest facility; but these accidents should not deter us from performing curettage, when it is necessary to prevent infection from retained placental debris.—*Union Médicale*, June 19, 1894.

Hydrastinin in Uterine Hemorrhage.—DR. KALLMORGEN, of the Woman's Polyclinic in Berlin, has just published a report of 86 cases of uterine hemorrhage of diverse origin, treated with hydrastinin. This report affords much needed information in regard to the *permanent* effects of this remedy. Dr. Kallmorgen administered hydrastinin in pills made according to the following formula:

Hydrastinin ....gm. 1.
Make into 30 pills.

These pills were generally borne well, though in a few cases they excited slight gastric irritation, and in others painful uterine contraction. Their hemostatic action varied according to the cause of hemorrhage. In 5 cases of hemorrhage due to retro-uterine hematocele, the flow was almost immediately arrested. In 25 cases of functional menorrhagia, the amount and duration of hemorrhage were reduced to normal conditions, and the dysmenorrhea, which complicated many of these cases, was partially or entirely relieved. Hydrastinin should be administered in functional menorrhagia a day or two before menstruation appears, and while it continues. Begin with two pills a day, and increase the number to three. Hydrastinin relieved 15 out of 18 cases of hemorrhage following abortion, and 3 out of 4 cases due to lesions of the annexes. Its effects were much less favorable in hemorrhage produced by chronic endometritis, as it positively benefited only 55 per cent. of these cases. In beginning abortion, it was successful in 37 per cent., and in uterine fibroids its hemostatic action was apparent in only 25 per cent. of the cases treated. In hemorrhage caused by cancer of the uterus, hydrastinin produced no effect whatever.—*Journal de Médicine de Paris*, July 15, 1894.

Treatment of Ovarian Cysts by Injections of Salts of Lithium, Ammonium, Lead, etc.—DR. G. M. DA SILVA JONES, of Lisbon, has used injections of salts of lithium, etc., in certain kinds of ovarian cysts since 1883, and he publishes the following conclusions: (1) Although ovariotomy is the treatment *par excellence* of ovarian cysts, there is a class of cases in which it cannot be performed, and these cases afford an opportunity for treatment by injections. (2) Unlike the old methods, this treatment, founded upon new physical principles, seeks to avoid vascularization and inflammation of the walls of the sac. (3) Membranes penetrated by a solution of nitrate of lead, and probably by all salt solutions of low molecular weight, are more quickly permeated by other salt solutions than they were before. (4) Solutions of salts of low molecular weight generally permeate membranes more quickly than others, and chloride of lithium surpasses all others in this respect, though it may itself be surpassed by fluoride of lithium. (5) The solution of chloride of ammonium, which penetrates membranes almost as quickly as the solution of salts of lithium, possesses besides, in nearly as great a degree as that of nitrate of lead, the property of rendering membranes more permeable to the passage of other solutions, and perhaps fluoride of ammonium will prove to possess this double property in a higher degree than sal ammoniac itself. (6) These properties of the different salts may be applied in the treatment of ovarian cysts, to modify the condition of their walls, or their contents, or both. (7) In this method of treatment, injections should be made by displacement, and the choice of salts should depend, as much as possible, upon indications furnished by a careful study of liquid taken from the tumor before injections, and by attentive consideration of the patient's condition. (8) If chloride of ammonium, or a chloride possessing similar properties, be not used by itself, the two salts employed should be administered at different times, and experience alone can determine the proper interval between injections, or whether it is not better to inject the two solutions at the same time. (9) Whatever the plan of treatment pursued according to this method, and whatever its immediate effect, it should be pursued until cure is attained, or accident occasions temporary or definitive interruption.—*Gazette de Gynècologie*, June 1, 1894.

SURGERY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal., and

G. F. SHIELS, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

Incision for Appendicitis.—McBURNEY (*Exchange*) describes a new method of operating in certain cases of appendicitis which promises a more perfect result, as regards the strength of the abdominal wall, than is usually observed. The incision in the skin is an oblique one, crossing a line drawn from the anterior iliac spine to the umbilicus nearly at a right angle, about 1 inch from the iliac spine, and is so situated that its upper third lies above that line. The section of the external oblique muscle and aponeurosis should correspond, great care being taken to separate these tissues in the same line, not cutting any fibers across. The edges of the wound in the external oblique are strongly pulled apart with retractors, displaying a considerable expanse of the internal oblique muscle, the fibers of which cross somewhat obliquely. These fibers and those of the transversalis muscle can then be separated with a blunt instrument in a line parallel to their course. The edges of this deeper wound are next separated with blunt retractors, thus exposing well the transversalis fascia, which is then divided in the same line. Last of all the section of the peritoneum is made. Two sets of retractors must be used, one holding open the superficial wound from side to side, the other separating the edges of the deeper wound from above downward. The muscular and tendinous fibers being separated and not divided, muscular action will rather approximate than draw apart the edges of the wound. There is scarcely any hemorrhage, except during incision of the skin. The transversalis fascia can easily be completely sutured, and there is but little pain after the operation. The operation takes more time than the usual one, and more assistance is necessary. It does not appear to be suitable for cases accompanied by suppuration about the appendix, nor in non-suppurative cases which require a large intra-abdominal dissection during operation. The author has performed this operation on four patients in the intervals between attacks of recurrent appendicitis.—*British Medical Journal*, August 11, 1894.

Persistent Edema and Elephantiasis following Fxtirpation of Lymphatic Glands.—RIEDEL (*Arch f. klin. Chirugie*) mentions how rarely cases have been published in which persistent edema or elephantiasis has been noticed after extirpation of lymphatic glands. These results of the operation, he thinks, are not really very rare, for he has himself observed them in three cases. The first was that of a boy, aged 12, where edema of the whole arm and hand was the result apparently of removal of lymphatic glands from the axilla three years previously. The second patient was a strong-looking man, aged 30. Some years previously he had contracted a soft chancre, and suppuration about the left inguinal glands followed. Since then the glands had always remained tender, and became swollen after much walking or after any excoriation of the glans penis; suppuration in both groins followed on one such occasion, and the sinus openings refused to heal. Riedel excised the inguinal glands, and found them studded with minute abcesses about the size of millet seeds. After the operation the wounds healed well by granulation, but, when seen about two years later, the patient was found to have some degree of elephantiasis of the skin of both thighs and the lower part of the trunk; he had also enlargement of the glands in the right axilla. The third patient was a strong-looking man, aged 30. A soft chancre, acquired three-quarters of a year previously, had given rise to suppuration in the left groin, and the sinuses would not heal. Riedel excised the left inguinal glands, and about half a year later an elephantiasis of the skin of the thigh developed itself. In both the second and the third cases the development of the elephantiasis was associated with repeated erysipelas-like attacks. Riedel declares himself uncertain about the advisability of complete extirpation of the inguinal glands in similar cases. *British Medical Journal*, August 4, 1894.

Curettage of the Rectum for Cancer.—At a recent meeting of the Académie de Médecine, Paris, M. QUÉNU presented a patient who suffered from cancer of the rectum for the last 5 years. When the man was seen for the first time, no operation was possible, and he was obliged to create an artificial anus. But this operation was insufficient, as the patient continued to lose a good lot of blood and to become rapidly cachectic from auto-infection. Thinking that curettage applied to advanced cancer of the uterus might be suitable to this case, M. Quénu performed this palliative operation with very good result. The hemorrhage ceased, as well as the auto-infection resulting from the cancerous mass. The patient gained 6 pounds in a month, all fetid odor had disappeared, and the rectum recovered its permeability. The speaker ended by saying that this operation might be more frequently practised to the great benefit of the patient.—*Medical Press and Circular*, August 1, 1894.

Resection of the Thoracic Wall for Dangerous Pulmonary Hemorrhage. ISRAEL reports the following case: The patient, æt. 39, had hereditary tendency to tuberculosis. In 1874 he had right-sided pleurisy, which in 1883 led to resection of the ribs, but without any particular result. In the autumn of the same year the speaker resected three ribs, but the suppuration still continued, and to this was frequently added hemoptysis. Under the influence of treatment by baths the suppuration diminished, but the tendency to hemorrhage still continued. On January 15th the patient presented himself with profuse hemorrhage which had continued uninterruptedly for 5 days. He was exceedingly pale, the right side of the thorax scarcely moved at all. Bright blood streamed out of the defect in the thoracic wall the size of a 5-shilling piece. The whole pleural cavity was filled with blood clot. By the aid of a laryngoscopic mirror and the electric light, after clearing out the cavity, the spot from which the blood continuously poured could be distinguished. It was in the upper part of the pleural cavity. Iodoform tamponade was first performed, but without any result. Hemoptysis immediately took place. As the patient's strength was diminishing in a threatening manner and hemoptysis with bacilli also came on, the speaker determined to seek out the bleeding spot. The operation was performed January 23d. From the fistulous opening an incision was made through all the soft parts 20 cm. directly upward; he then resected the ribs from the 2d to the 6th, 8 cm. each, slit the thickened pleura, resected it, and now had the upper part of the pleural cavity completely open. It was then seen that the blood streamed from the upper part where the costal pleura passed into that of the lung. Along with the blood bubbles of air burst through, showing that the parenchyma of the lung was also opened. The whole pulmonary pleura was converted into granulation tissue with shallow tuberculous ulcers. The speaker then pressed a pledget of sterilized Penghawar-Jambi enveloped in gauze for several minutes on the bleeding spot, and after cessation of the hemorrhage filled the whole remaining cavity with iodoform gauze. By this means, not only the direct hemorrhage, but the hemoptysis, were definitely arrested—a proof that both arose from the same ulceration. The gauze was removed on the fourth day. The pleura was then treated by painting with tincture of iodine and calomel, powdering later with arg. nit. and iodoform-ether spray. Under this treatment the cavity cleansed and contracted, and the greater part became covered with epidermis, which had pushed in from the margin of the skin. The man had gained 30 pounds in weight. The operation was not only useful in saving life at the time, but it made the diseased pleura accessible to successful local treatment.—*Medical Fress and Circular*, August 1, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

Intra-Laryngeal Therapeutics.—Dr. Gordon Sharp says that intra-laryngeal injections were at first made with a view of applying antiseptics directly to the lungs, of killing the bacillus, or of alleviating the troublesome cough. A communication from Prof. Grainger Stewart shows the value of this plan of treatment in bronchiectasis, and the author believes that this is the disease which is likely to be most influenced by intra-tracheal treatment. By applying creasote, guaiacol or other antiseptics directly to the interior of the trachea, whence it is certain to trickle down into the bronchial tubes, one may be able to prevent, to a great extent, the formation of putrefactive bodies and mild attacks of septicemia. The most probable cause of bronchiectasis is an atrophy of the walls of the bronchial tubes. The resulting dilatation goes on increasing unless checked, and nothing so much tends to aggravate the condition as the filling up of the cavities and decomposition of the contents, with the production of foul gases. If the secretion can be lessened, and the cavities kept comparatively sweet, the tissues are given a chance of regaining a certain amount of tone, while at the same time those septicemic attacks are prevented; the comfort of the patient is also increased by diminishing the disagreeable odor and by relieving the irritating cough so frequent in bronchiectasis. Drugs injected into the trachea, while exerting a local action in the lung and bronchial tubes, find their way into the circulation. In a case in which a solution of menthol and guaiacol in olive oil was so administered, the menthol was detected in the urine two hours later. One can hardly hope to obtain brilliant results by intra-laryngeal method in cases of phthisis. Antiseptics so used have little effect upon the course of the disease in general; but for the alleviation of the cough a 10-per-cent. solution of menthol in olive oil, or in one of the pure preparations of higher paraffines, is often of great service. The application of injections intra-laryngeally at first appears to be difficult, but it is really a very simple one. The patient sits facing a good light, and is told to pull the tongue well forward, and to take a few deep breaths. The doctor stands or sits a little to his right, from directly in front of the patient. The syringe is filled and the point passed over the tongue in a slanting direction and not directly over the center. Thus the tip of the epiglottis, which is so sensitive, is avoided. The fluid is slowly forced, drop by drop, into the larynx. One should catch the glottis just as the patient has taken an inspiration. This gives sufficient time to inject a fluid drachm before the patient is obliged to breathe again. This may be repeated several times at a sitting, in case it is deemed necessary. Some of the paraffin preparations are generally preferable to other oils, as they do not become rancid. The drugs usually employed are of an antiseptic nature, such as creasote, guaiacol (2 per cent.), menthol and thymol (5-10 per cent.), salol (5 per cent.), salicylic acid (2 per cent.), carbolic acid (1 per cent.). A good solution consists of guaiacol (2 per cent.), menthol (10 per cent.), and olive oil (88 per cent.). One fluid drachm of this solution may be injected into the trachea in cases of fetid bronchitis, bronchiectasis, or pulmonary phthisis. Other drugs may be used, provided they are conveyed in a non-irritating fluid and are of such a nature as not likely to cause local injury.—*Lancet.*

New Experiment on Keratoplasty and Measures Against Prolapse of Iris in Simple Extraction.—At the International Medical Congress, DR. VAN MILLINGEN reported his experience in attempting to restore vision in cases of extensive leucoma, especially in cases of totally adherent leucoma with degeneration of the lens. In such cases the author trephines the leucoma as far as the vitreous, removes the calcified lens, and applies Sulzer's contact glass. In one case the vision remained good for a year and a half, in another for 3 months. In a third case panophthalmitis set in 5 months after the operation. After simple cataract extraction, Dr. Van Millingen applies very thin contact glasses to prevent prolapse of the iris. An assortment of them must be on hand and adapted to the eye, under cocain, before the operation. It is applied immediately after the operation. The air bubbles are driven out with a 4-per-cent. boric acid solution. The eye is washed with the same solution at each dressing. The glass is left in place until the fourth day. In fifteen cases the author had perfect success, with a most speedy and equal wound healing. The frequency and degree of post-operative astigmatism are lowered by this method. *Archives of Ophthalmology*, July, 1894.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M.D., Sacramento, Cal.

Erysipelas and Gonorrhea.—DR. ALEXANDER SCHMIDT reports (*Centralblatt f. Gynäkologie*) an interesting case of gonorrhea, in which a superadded attack of erysipelas apparently displaced or cured the patient of the former trouble. The patient, a girl of 3 years, came under his care for the treatment of gonorrhea of the vulva. On the third day there appeared on the left thigh and gluteal region a typical erysipelatous patch that was separated by about two fingers' breadth from the vulva. Immediately the temperature rose, and the purulent secretion decreased. The erysipelas spread over the lower extremities, and passed away after a week. The inflammatory condition of the vulva and urethra passed away the second day after its appearance, and did not return. *International Medical Magazine*, June, 1894.

Treatment of Cystitis by Sublimate Injections.—COLIN reports 34 cases so treated, the results of which are: 12 cases recovered, 9 very much benefited; 9 improved, and 4 remained uninfluenced. It is important to remember that the first injections sometimes give great pain. Every second day is often enough in the commencement; later, the injections may be given daily, increasing from weaker to stronger solutions. Corrosive sublimate solution (1:500) is the strongest used, and can be borne only by bladders affected with cystitis. The amount usually injected is from 5 to 10 grammes in the bladder, and from 10 to 15 drops in the posterior urethra and neck of the bladder.—*Centralblatt f. Chirurgie.*

Massage of the Seminal Vesicles.—Fifteen cases of chronic urethral discharge dependent on the retention of the seminal fluid in the vesicles are reported as cured by DR. EUGENE FULLER'S massage treatment or stripping of the seminal vesicles (*Journal of Cutaneous and Genito-Urinary Diseases*). This method is to insert the greased forefinger into the rectum and stroke the seminal vesicles. This stripping process forces out the retained semen. Repeating the treatment once a week he claims to accomplish very happy results in relieving the chronic urethral discharges dependent on vesiculitis.

Syphilis and Tabes in Japan.—M. GRIM states that tabes is very rare in Japan, while syphilis is quite frequent. This is owing to the sensibility of the nervous system of the Japs. He concludes that syphilitic infection will not explain the frequency and development of locomotor ataxia as much as authorities have alleged.—*Journal de Médicine de Paris*, July 15, 1894.

The Ideal Treatment of Acute Gonorrhea—Is It Justifiable?—BURNSIDE FOSTER recommends a button-hole opening in the perineum, through which the bladder is drained, in acute gonorrhea. The anterior urethera can then be properly flushed out from behind forwards, obviating the carrying backward of the gonococcus. The author candidly remarks: "I have never had the opportunity to adopt this method of treatment, which, should it be deemed advisable, would naturally have but a limited field."—*Journal Cutaneous and Genito-Urinary Diseases*, September, 1894.

The Hypodermic Injection of Mercurials in the Treatment of Syphilis—At the last meeting of the French Congress of Dermatology and Syphilography, held at Lyons, M. AGAGNEUR read an exhaustive report, *Union Médicale*, on the hypodermic use of mercury in the treatment of syphilis. He took a decidedly adverse view to its general use, stating that the indications for employing it were hard to determine. From his large experience and thorough investigation of the subject, he had come to the following conclusions: (1) The use of mercury by hypodermic medication in the treatment of syphilis should be reserved for a few exceptional cases, because of the inconvenience and dangers to which it exposes the patient. In this connection he emphasizes the great pain of the injections, the dangers of abcess formation, of sudden death from syncope, fat embolism and rapid mercurial intoxication. (2) It should be used only after careful deliberation in cases where it is needful to have large doses of mercury absorbed immediately, mainly in cases of cerebral syphilis. If this urgency for rapid absorption does not exist, the method of treatment should always be by injection or pills, one or both.

In the discussion which followed this paper, the opinion of the Congress seemed about equally divided for and against M. Agagneur's extreme views. M. STANKOWENKOW of Kiew strongly defended the use of soluble mercurials hypodermically. He had used the following formula in 200,000 cases, always with success. Its action was sure and rapid, and he had never seen a serious accident. His preparation, invariably used, is:

Benzoate of mercury	0 .25.
Chloride of sodium.	
Hydrochlorate of cocain	āā..0 .06.
Distilled water	30.

Of this he injects two grammes each day for a month; then waits two months, and again gives the same treatment, continuing it at longer intervals.

M. JULIEN also defended the hypodermic method. He used it in all grave and stationary lesions. He considered local abscess formation rare if the asepsis was rigid.

The sentiment of the Congress in closing the discussion was that, while the hypodermic method was not to be advised for general use, it nevertheless was an invaluable aid in hospital practice and in grave cases, and that the accidents emphasized in M. Agagneur's report might, in the majority of cases, be avoided by care and rigid asepsis.—*Boston Medical and Surgical Journal*, September 6, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Sozoiodol.—TEICHMANN has used sozoiodol in affections of the external ear accompanied by much discharge, and found the drying properties of the drug to be very satisfactory. It was also serviceable in chronic discharge of the middle ear, with destruction of the tympanum. Sozoiodol appeared to prevent the recurrence of aural polypi, but does not cause them to shrink or disappear. In caries the results obtained are better than those from any other remedy. In the various forms of rhinitis the potassium and zinc salts of sozoiodol are very effective. The latter may be somewhat irritating at first, but acts with astonishing rapidity. In the after treatment of operations on the nose, the author has now discarded iodoform, preferring the sozoiodol of potassium.—*British Medical Journal*, June 23, 1894.

Apocynum Cannabinum in Heart Disease.—A. G. GLINSKI, after having proved experimantally that the root of the apocynum cannabinum contains a poison which, in large doses, paralyses the heart, and when given in small doses retards and strengthens its beat, decided to take it himself, as he is suffering from hypertrophy of the left ventricle, with intercurrent attacks of dilatation of the organ, mitral murmur, dyspnea, etc. The dose was fifteen minims of the fluid extract three times daily. As he found that all his symptoms disappeared in two days, he gave it to other patients in the same quantity in cases of palpitation or deficient compensation, in which strophanthus and adonis vernalis had failed, and digitalis seemed contraindicated. The following is a summary of his experience: (1) The action of the root of apocynum cannabinum is similar to that of digitalis, without being cumulative. (2) In cases of dilatation, the fluid extract rapidly diminishes the area of dulness. (3) It increases the daily amount of urine, stops the palpitation, and promotes the absorption of transudations. (4) With the exception of increased pulsation of the arteries of the head, it has no bad secondary effects. The drug may be used either as a decoction (ʒi to ℥viii) three to four tablespoonfuls daily, or as tincture (1-10) m.xv, t.i.d, or fluid extract, m.x to m.xxx, t.i.d.—*British Medical Journal*, June 23, 1894.

The Treatment of Typhoid Fever.—DR. CLAUD MINCHEAD, in his "Edinburgh Hospital Report," gives an excellent epitome of the treatment of typhoid fever. Instead of locking up the bowels, he advises the administration of castor oil or calomel, if the patient has not had a movement on the previous day. He also regards calomel as an antiseptic, and recommends its use in doses of one grain, when an aperient is called for, combined with opium if it prove too active. Of the other antiseptics, benzo-naphthol, in sixteen grain doses every four hours, or half doses oftener, has proved, in his hands, the most efficacious. Another point which is strongly emphasized is the impropriety of insisting upon patients using the bed-pan, when the annoyance and straining incurred neutralizes the benefit; allowing them quietly to rise to the bed-stool, unless when the patient is very weak or hemorrhage is threatening, never has been followed by any unfortunate result in his experience. Diarrhea may be checked by liquor calcis, salicylate of bismuth, or Dover's powder with ipecacuanha. The antipyretic treatment is useless, but antipyrin now and then relieves the headache or other nervous symptoms. Turpentine in capsules may be given for the relief of meteorism, and also in hemorrhage, when it should be combined with morphin. For diet, milk, peptonized if necessary, and plenty of cold water; and for stimulant, whisky in warm milk or soda water, or again, in white of egg mixed with cold water to which a pinch of sugar is added. "If the patient tires of this, wine may be given—by preference the red wines—or light beer, *e. g.*, Pilsener."—*Medical Press and Circular*, July 18, 1894.

Chloral Hydrate in Hemoptysis.—J. Pal reports 15 cases which were treated for hemoptysis by injecting 15 or 25 grains of chloral hydrate into the rectum, and an effect was always produced within half to three-quarters of an hour. Several times repeated doses were given, and as a prophylactic the drug also seemed to be valuable.—*British Medical Journal*, July 14, 1894.

MEDICINE AND PATHOLOGY.

By Albert Abrams, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

The Diagnostic and Prognostic Importance of Leucocytosis.—In an interesting and very suggestive article, Dr. Richard C. Cabot, of the Massachusetts General Hospital, summarizes his investigations in this direction. Leucocytosis is not leukemia, though some still confuse the two conditions. The former is transitory, as a general rule, while the latter certainly is not. The percentage of white corpuscles does not distinguish one from the other, as leucocytosis may show as marked an increase in numbers as leukemia. The best definition thus far given of leucocytosis is this: Leucocytosis is the presence in the blood of an increased number of white cells of the same varieties morphologically as those in normal blood, an overwhelming plurality being polyneuclear. In leukemia, the polyneuclear cells are never increased and are generally in the minority. In leukemia, too, there are found very many large mono-neuclear cells. The importance of this differential point is readily seen when we consider the fact that a large increase of white corpuscles occurs with abdominal tumors, including splenic growths in which the corpuscles are overwhelmingly polynuclear. Again, cases of leukemia have been observed in which the normal number of white corpuscles existed, but the *character* was changed, the large, mono-neuclear supplanting the polyneuclear cells. The majority of observers now estimate the normal number of white corpuscles as 7,500 in the cubic millimeter, and any variation of 1,500 above or below is considered abnormal. Leucocytosis is found in a considerable number of physiological conditions, and due consideration must be given to this fact. During digestion, two and a half hours after a hearty meal, the increase is apt to be from 1,000 to 7,000 above the normal, and in some cases no leucocytosis is observed during digestion. Pregnancy and the puerperal state, in about two-thirds of the cases, show leucocytosis, as much as 14,000. Children.—The new-born show considerable leucocytosis, which gradually lessens till the sixth year. Hemorrhage causes it also, the increase occurring just after a considerable loss of blood. Taking up diseases, the following conclusions are drawn from the hospital investigations: Most febrile diseases show leucocytosis, but the previous statements of some of the best authorities have been wholly incorrect regarding typhoid fever, the conclusions having been drawn from reasonings rather than from actual clinical observations. According to Dr. Cabot, the existence of this blood state in typhoid fever points to some complication, such as thrombosis, pneumonia, abscess, etc. The blood count, therefore, in temporary rises of temperature during typhoid, would be of importance as distinguishing a relapse from some complicating condition. In 79 cases of typhoid fever, blood counts were made; in 49 of them the number of white cells was sub-normal, and in the others normal. In many other affections which might be mistaken for typhoid, leucocytosis is found as local suppurations, purulent meningitis, thrombosis, pneumonia. Appendicitis, in some cases, closely resembles typhoid, and here leucocytosis would be found. In *la grippe*, those cases examined showed no blood change. In pulmonary tuberculosis and meningeal tuberculosis, no aid is given in different rating from typhoid by the blood-count. The same applies to malaria. The diagnosis of pneumonia from *la grippe*, and of the appearance of pneumonia with, as well as the prognosis in pneumonia, is greatly aided by the recognition of leucocytosis. Appendicitis gives leucocytosis when it is purulent. The diagnosis of this condition, from a colic due to constipation, is of great importance, because of the possibility of the rupture of an uncapsulated abscess, by giving a purge. In a doubtful case we may more confidently purge if the blood-count shows no leucocytosis. In cases of suspected purulent abdominal affections, the diagnosis of pus is warranted by the presence of leucocytosis. In osteomyelitis, otitis media, housemaid's knee, and several cases of arthritis, those showing leucocytosis turned out to be purulent, while those giving normal blood-count were non-purulent. After operations where the temperature rises, leucocytosis points strongly to pus-formation.—*Boston Medical and Surgical Journal.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M.D., Assistant Physician, State Asylum for Insane,
Stockton, Cal.

A Case of Cortical Blindness.—Five new cases of cortical blindness have recently been published, one of which, reported by Dr. H. Magnus of Breslau, is the following: G. B., 52 years old, well nourished, of regular habits, has had lues. Thirteen years ago he had a sudden attack of left hemiparesis and left homonymous hemiopia, during which he did not lose consciousness but showed a remarkable weakness of memory. These symptoms disappeared in the course of some weeks with the exception of the blindness of the left halves of the visual fields. Ten years after this attack a second one occurred, during which he lost consciousness for several days. The third attack, which followed the second after an interval of three years, set in while the patient was walking on the street. The symptoms were a right hemiopia, with loss of consciousness lasting but a short time and impairment of memory for recent events. No muscular paralysis was present. Three weeks after the attack the patient was seen by Dr. Magnus, who was told that the man was blind. It was found, however, on closer examination that a small central visual field in each eye was intact. The patient could distinguish several letters of the Snellen's tables with both eyes; with the right better than with the left. His eyes would oscillate to and fro, and it was only by chance that they would be fixed upon the letters, which made reading very difficult. It was impossible to test his field of vision with the perimeter; he could not even follow the finger with the eyes after touching the point of his nose to help him locate it. He could not locate objects, could not find his way about his room, describe familiar roads, houses, or name the number or position of the doors, etc., in his room. His optical memory was unimpaired; he recognized objects if he could see or feel them. He could reckon and write correctly. The ophthalmoscopic and physical examinations revealed nothing abnormal. A complete change in these symptoms took place eight weeks afterward; his eyesight improved, and the greatest acuity of vision, instead of being central, was found to be excentric, as indicated by the patient rotating the eye-balls inward and downward. His sense of color was found normal. Symptoms of dementia were developing. This history points to a cortical lesion. The remarkable disturbances of topography and inability to locate objects have been observed in other cases in connection with cortical blindness, and it has been proved that double homonymous hemianopsia by no means always entails complete loss of the eyesight; but that sometimes a small central field of vision retains its function.—*Deutsche med. Wochenschrift—Journal of Nervous and Mental Disease.*

Modern Treatment of Idiocy.—According to BOURNEVILLE, idiocy occurs as a symptom of the following diseased conditions: Hydrocephalus, arrested development of convolutions, congenital or pathological malformations of the brain, meningitis or meningo-encephalitis, hypertrophic cerebral sclerosis, atrophic sclerosis, myxedema and cerebral tumors. Bourneville has published the results of a comparative study made by him of the skulls and photographed brains of 22 idiotic children, whose feeble-mindedness was dependent upon different causes, and who had died of a variety of diseases. The age of the children averaged from two to seventeen years; they were all typical idiots and they belonged to the same category as the 25 patients operated upon by Lannelogue. Bourneville's conclusions from his observations differ in certain particulars from those of other observers. He lays, especially, stress upon the following points: The surgical treatment of idiocy rests upon a hypothesis not substantiated by pathological anatomy. In the different forms of idiocy, premature ossification of the cranial sutures does not exist. Partial synostosis is quite exceptional. Lesions causing idiocy are generally profound, extensive and varied, and most unlikely to be influenced by craniectomy. Our present means of investigation are not such that a diagnosis of premature ossification and thickness of the skull can be made. Reports of most surgeons show that results of operations are negative, slight or doubtful. Serious accidents, as paralysis, convulsions or death, may follow surgical interference. Medico-pedagogic treatment, founded by Seguin, and improved by the introduction of new processes, always permits a decided amelioration, and often enables idiotic children to occupy some social station. This medico-pedagogic treatment has been greatly improved upon by Bourneville. The children are first taught to stand erect, to walk properly, to wash their faces and hands, to dress themselves, to lace their shoes, and perform other complicated acts. These object-lessons are given upon the manikin or upon one of the little patients. The joints are exercised, the muscles are rubbed, baths are administered and a general hydrotherapy employed. For the development of speech and correct pronunciation, methods in vogue in deaf and dumb asylums are utilized. Every device is employed to render numbers and calculations real and intelligible. The training of vision is carried on out of doors, in gardens or plots laid out with this object in view. Music occupies an important place in this scheme of mental and moral development. There are songs and movements, games and lessons in vocal and instrumental music for the advanced pupils. Physical culture is carried on by means of systematized mechanical movements, gymnastics, fencing and dancing. Technical training for a trade completes the course of instruction. There are seven workshops. The pupils learn carpentry and locksmith work, printing, tailoring, the making of shoes, baskets, brushes, twine, etc. Bourneville calls attention to the fact that many backward and imbecile children are moral imbeciles. They are unstable, perverse, impulsive, disorderly and wayward. They reach a certain stage of development, a moderate intellectual capacity; the moral qualities are in abeyance; and moral imbeciles have as much mind as is consistent or possible with a total absence of character.—*Progrès Medical—Journal Nervous and Mental Diseases.*

FORMULÆ.

By GEO. B. SOMERS, M. D., San Francisco, Cal.

Freckles.—

White precipitate of mercury.	
Subnitrate of bismuth	āā gr.xx
Spermaceti.	
Yellow wax	āā ʒi–℈ii
Almond oil	ʒiiiss

S.—To anoint the affected parts. Repeat the frictions eight successive nights.—*Nouveaux Remèdes.*

Toothache Drops.—B. H. BRODNAX prescribes:

Camphor.	
Chloral.	
Glycerin.	
Carbolic acid	equal parts

S.—Apply to cavity on cotton after cleansing.

Earache.—B. H. BRODNAX orders:

Chloral	gr.x
Camphor	gr.x
Carbolic acid	gr.x
Castor oil	℥ss

S.—Warm and drop into the ear until ear is full. Then apply piece of cotton wet in warm water to external ear, and cover the whole with cloth wrung out of hot water.

Bromoform in Whooping-Cough.—CARPENTER recommends:

Bromoform	m.xlviii
Alcohol	ʒiv
Tr. card. comp.	*ad.* ℥iii

S.—Teaspoonful in water three times a day for a child two to four years old.—*Philadelphia Polyclinic.*

Chronic Bronchitis.—

Ammonii chloridi	gr.xv
Ammon. carb.	gr.xv
Pulv. ipecac	gr.iii
Morph. hydrochlor.	gr.i
Mucil. acaciæ	q.s.

Divide into ten pills.

S.—One night and morning.—*Medical Press and Circular.*

Lubricant for Urethral Instruments.—GUYON uses:

Glycerini	ʒvii
Hydrarg. perchlor.	gr.¼
Saponis mollis	℥ii
Aq. dist	ʒvi

This preparation is antiseptic and causes no irritation to the urethral canal.—*Medical Press and Circular.*

Method of Administering Diuretin.

Natrio. salicylate of theobromine	gm.4-6
Peppermint water	gm.100
Distilled water	gm. 90
Simple syrup	gm. 10

S.—To be taken in one day, two tablespoonsful at a time, every two or three hours.—*Nouveaux Remèdes.*

Antirachitic Powder.—

Precipitated carbonate of lime	gm. 32
Phosphate of lime	gm. 15
Lactate of iron	gm. 3
Lactose	gm. 50

S.—Place in a half liter of milk as much as can be held on the point of a knife.—*Nouveaux Remèdes.*

Creosote in Phthisis.—S. SOLIS COHEN gives:

Creosoti (beechwood)	m.xxx-lxxx
Tinct. cardamomi	ʒiv
Glycerini	℥ii
Alcoholis *ad.*	℥iv

S.—Two teaspoonfuls in water after meals.

Hepatic Stimulant.—

Euonymin	gr.ii
Pil. colocynth. co.	gr.ii
Ext. hyoscyami	gr.ss

To make one pill.

S.—One or two at bedtime.

Guaiacol.—

Guaiacol. Tr. gentian. comp. āā	equal parts

This mixture may be administered in ten-drop doses in milk before meals.

Phthisis.—

Creosoti	m.vii
Iodoformi	gr.vi
Acidi carbolici (cryst.)	gr.viii
Ol. therbromæ	q.s.

Divide into thirty pills.

S.—One pill every three hours.

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for August, 1894.—The deaths registered in 75 town districts of the State, during the month of August, in a population of 777,053, correspond to an annual rate of 15.36 a thousand, the total mortality having been 1002. 107 deaths were due to zymotic diseases, giving an annual rate of 1.56 a thousand. Of these, 9 were due to diphtheria, 23 to cholera infantum, 33 to typhoid fever, 16 to diarrhea and dysentery, 7 to cerebro-spinal fever, 6 to whooping cough, 7 to croup, 5 to intermittent and remittent fevers, 1 to scarlet fever, 0 to measles, and 0 to small-pox. 235 deaths resulted from diseases of the respiratory organs, giving an annual rate of 3.62 a thousand. Of these, 163 were due to consumption, 41 to pneumonia, 26 to bronchitis, and 5 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.52 and .62, respectively. 76 deaths resulted from diseases of the heart, 6 from alcoholism, 4 from erysipelas, 35 from cancer, and 445 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 589,000, was 16.08 The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Fresno and Berkeley.

METEOROLOGY.

Summary for August.—*Temperature.*—The normal temperature of the State for August is 74°, the average for August, 1894, was 75°; a departure from the normal of +1°. The highest monthly mean was 99°, at Salton, in the desert regions of San Diego county; the lowest, 54°, at Point Reyes. The maximum temperature was 120°, at Volcano Springs, on the 1st, in the desert regions of San Diego county; the minimum 35°, at Boca, in the high mountain regions of Nevada county, on the 12th. The absolute monthly range was 85°; the greatest local monthly range was 68°, at Escondido; the least, 31°, at Eureka.

Rainfall.—The normal precipitation of the State for July is 0.03 inches; the average for August, 1894, was 0.05 inches; a departure from the normal of +0.02 inches. The greatest monthly precipitation was 1.45 inches, at Meadow Valley, Plumas County; the least, nothing, at a number of stations.

Wind.—The prevailing direction of wind was westerly.

Unusual Features.—The unusual meteorological feature of the month was the great number of thunder and lightning storms throughout the State; there having been fifteen different storms noted, some being quite severe.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for August, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn ....Cal.	82.0	106	60 0	----	----	----	1	T.	----	----	----	----	E.	Southern Pacific Company.
Berkeley......... "	59.0	93	47.0	71.0	55 0	16.0	0	0.00	86 0	19	8	4	S.	Obs. University of California.
Colfax............ "	84.0	104	58.0	----	----	----	1	0.03	----	----	----	----	N.E.	Southern Pacific Company.
Eureka........... "	57.0	79	48.0	62.0	53.0	9.0	1	0 04	90.0	6	10	15	N.	Weather Bureau Dept. Agr.
Fresno........... "	82.0	109	55.0	99.0	65 0	34.0	3	T.	36.0	26	5	0	N.W.	" " "
Indio............. "	90.0	114	80.0	----	----	----	0	0.00	----	----	----	----	W.	" " "
Los Angeles.... "	70.0	97	52.0	82.0	58.0	23.0	1	0.01	78.0	9	22	0	W.	" " "
Monterey .... "	62 0	86	50.0	----	----	----	0	0.00	----	----	----	----	N.W.	Southern Pacific Company.
Napa........... "	69.0	102	51.0	80.0	58.0	22.0	1	0.04	70.0	12	17	2	S.W.	Station Napa Insane Asylum.
Oakland......... "	59 0	90	45.0	72.0	54.0	18.0	0	0.00	84 0	13	11	7	W.	Chabot Observatory.
Paso Robles.... "	73.0	105	40.0	91.0	54.0	37.0	1	0.05	34.0	29	1	1	W.	Agr. Ex. Station.
Red Bluff....... "	82.0	110	60.0	98 0	66 0	31 0	1	T.	37.0	26	5	0	S.	Weather Bureau Dept. Agr.
Sacramento. ... "	75.0	108	50 0	91.0	58.0	33.0	2	T.	59.0	0	28	3	S.W.	" " "
San Bernardino "	75.0	102	41.0	92.0	59.0	33.0	2	0.16	----	----	----	----	----	A. K. Johnson, M. D
San Diego....... "	67.0	90	55 0	79.0	62.0	11.0	1	0.04	82.0	23	5	3	W.	Weather Bureau Dept. Agr.
San Francisco.. "	59 5	91	49.0	65.0	53.0	12.0	0	0 00	87 0	14	11	6	S.W.	" " "
Santa Barbara.. "	66.0	90	54.0	73.0	58.0	15.0	0	0.00	76.0	20	9	2	W.	Hugh D. Vail.
Santa Cruz...... "	65.0	101	46.0	77.0	54.0	23.0	1	T.	----	20	6	5	W.S.	W. R. Springer.
Yuma...........A. T.	90.0	110	66.0	103	77.0	26.0	2	0.10	47.0	15	16	0	S.W.	Weather Bureau Dept. Agr.

Average humidity at Paso Robles is at 2 P. M. T. means a trace of rain. Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: OCTOBER, 1894.

A PROPOSED AMBULANCE ASSOCIATION FOR SAN FRANCISCO.

A movement is on foot in San Francisco for the formation of an ambulance association. It is understood that the objects in view are principally to improve the local emergency service, and to spread the knowledge of "First Aid to the Injured." The name "Red Cross" has been used in connection with the proposed society. If the objects are simply as stated, the employment of this title would hardly be appropriate. The scope of Red Cross societies is very distinct. There is an American Association of the Red Cross, with headquarters at Washington, the leading spirit of which is Miss Clara Barton, the American Florence Nightingale. This association is a branch of an international organization instituted at Geneva in 1863. Its original object and scope were limited entirely to ambulance work in connection with the army and navy; but as the United States branch could not, for obvious reasons, support an *active* society in connection with its army and navy, it was allowed by special modification of the international treaty to extend its work to affording relief in cases of national calamity, such as floods, fires, earthquakes, pestilence, etc. On the other hand, there are in Scotland and England two associations devoted to local ambulance work, whose objects cover the grounds of the proposed association. These are the St. Andrew's Ambulance Association of Glasgow, and the St. John's Ambulance Association of London. There is, then, a distinct difference between a Red Cross society and an ambulance association. The one is national and militant, the other local and educational. The idea at the bottom of the ambulance movement is admirable. The work in England and Scotland has proved its practicability. There the associations have been the means of imparting instruction in "first aid" to thousands of people, with excellent practical results. In directing attention and interest to this subject, not only is the educational influence on individuals excellent, but reflexly the public institutions must be the gainers thereby. Probably the chief causes of the inefficiency of public charities are the lack of knowledge concerning them and the lack of interest in them. An active ambulance association could not but arouse interest in the public ways and means of caring for the sick and injured; and once the knowledge of the needs and workings of the public charities become general, the demands for higher standards of efficiency will soon follow.

NOTES.

Mississippi Valley Medical Association.

The twentieth annual meeting of the Mississippi Valley Medical Association will be held at Hot Springs, Arkansas, November 21st, 22d and 23d. Many valuable papers have already been promised, and it is confidently stated that the success of the meeting is already assured. The month of November is usually one of the pleasantest of the year at Hot Springs, and the local physicians, together with the citizens, have united to offer the Association a hearty welcome. Substantial reductions in railroad rates have been assured, and these will be announced later.

Fairchild Bros. & Foster.

On the evening of July 29th, Messrs. Fairchild Bros. & Foster, the well-known manufacturers of digestive ferments, were burned out of the offices and warerooms which they had long occupied at Nos. 82–84 Fulton street, New York. The second day after the fire quarters were secured in the Rhinelander Building, where even better facilities were afforded for the transaction of their extensive business. The firm have issued a circular to their friends, expressing their hearty thanks for their forbearance with orders delayed or only partially filled, which was unavoidable with such an interruption to business. They are now prepared to give matters prompt attention, and have an ample stock on hand. This firm is one whose dealings with the profession have always been satisfactory, and there are few physicians who are not familiar with the products that they have done so much to improve and perfect.

Kentucky School of Medicine.

The thirty-ninth annual session of this flourishing school will begin January 3, 1895, continuing for six months. The Faculty have recently completed numerous improvements in connection with the school that will greatly add to its facilities. A large hospital, which will be one of the most complete for surgical work in this country, has been erected adjoining the college, and will soon be ready for the reception of patients. Extensive improvements have also been made in the laboratories, and during the ensuing session the facilities for clinical and laboratory instruction will be equal to any western school. Attendance is required upon three graded courses of six months, in three separate years. This school is a member of the Southern Medical College Association, but its requirements are more rigid than the standard of the Association demands. At the graduating exercises, in June last, the class numbered 188.

California Northern District Medical Society.

The fourth annual meeting of the California Northern District Medical Society will be held in Marysville, Tuesday, October 9, 1894. The Committee of Arrangements, consisting of Drs. David Powell, G. W. Stratton, T. P. Peery, A. E. Kosby and E. E. Stone, have been at work for some months past, and there is every reason to anticipate a very successful meeting. A circular letter has been issued to the physicians of Northern and Central California, pointing out the scope of the Society and urging a large attendance. The Society will convene in Masonic Hall, and will be welcomed by the Mayor of the city. There will be three sessions, the morning session opening at 10 A. M., when the annual address will be delivered by the President, W. A. Briggs, of Sacramento, and the afternoon and evening sessions, at 2 and 7 P. M., respectively. It is expected that the business of the afternoon session will be concluded sufficiently early to permit of the visitors seeing some of the beautiful surroundings of the city. The evening session will be devoted to the miscellaneous business of the Society, including the election of officers for the ensuing year. After adjournment, there will be a banquet at the New Western Hotel, tendered by the Medical Society of Yuba and Sutter Counties. The following are the titles of papers, with their authors and the names of those who will open the discussions: "When and How Shall We Apply the Obstetric Forceps?" W. R. Cluness, San Francisco; W. R. Cleaveland, Biggs. "Chronic Interstitial Nephritis," J. Ellis Rodley, Chico; G. W. Stratton, Marysville. "The Dietetic and Therapeutic Management of Typhoid Fever, Thos. Ross, Sacramento; O. Stansbury, Chico. "The Foothills of the Sierras in the Climatic Treatment of Bronchial and Pulmonary Diseases," R. F. Rooney, Auburn; F. W. Benjamin, Oroville. "Tenorraphy," T. W. Huntington, Sacramento; W. E. Bates, Davisville. "Head and Brain Injuries," S. J. S. Rogers, Marysville; W. W. Macfarlane, Woodland. "Gangrene of Scrotum and Penis," T. W. Serviss, Oroville; O. C. Hawkins, Biggs. "Strabismus, with Especial Reference to Its Early Recognition and Treatment," W. E. Briggs, Sacramento; C. H. Gibbons, Arbuckle.

"The Microscope in the Diagnosis of Enteric Fever and Tuberculosis," S. M. Mouser, San Francisco; J. R. Todd, Gridley. "The Treatment of Gonorrhea by Retro-injections," W. J. Hanna, Sacramento; N. Watts, Chico.

Folie à Deux.

This curious form of insanity seems to be rare. It is a form of induced insanity, and occurs where one person suffering from some delusion or hallucination has influence enough to develop in another the same form of trouble. Favorable conditions for the occurrence of *folie à deux* are similar predisposition, long-continued and great intimacy of the two patients, and lastly plausibility of the insane ideas. The case of the two Schaefer women, mother and daughter, who were recently committed to an asylum from San Francisco, appears to have been one of this nature. The mother became possessed of the idea that she could aid the police department in solving the mystery of the celebrated Jacobson murder. She was given a careful hearing by detectives, but after thorough investigation she was deemed to be suffering from an hallucination, though she was apparently rational on other topics. For some time she ceased to trouble the police, and was not heard from until some months later, when a prominent lawyer began to receive letters from her daughter, containing threats, rambling remarks about the Jacobson case and allusions to a promised marriage. The daughter was arrested and charged with insanity. While under detention in the San Francisco Receiving Hospital the mother visited the daughter, and, when questioned by the physician in charge, maintained stoutly that her daughter was suffering from no delusions, but was stating nothing but facts. The delusions, however, were plainly apparent, and the physician recommended that the mother likewise be charged with insanity. When brought before the insanity commissioners the patients demanded a jury trial, and a lawyer, who rides insanity cases as a hobby, volunteered to defend them. After a vigorous defense by the attorney the jury disagreed, and the judge dismissed the case. Three days later this same attorney, having allowed himself due time to enjoy his victory, appeared before the judge with the petition that the dismissal be vacated; that his clients be taken into custody once more, and that they be committed to an asylum in due form, all of which was forthwith done.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, August 21, 1894.

The President, W. F. WIARD, M.D., in the Chair.

The Use of Tobacco by the Medical Profession.—DR. W. F. WIARD read a paper on this subject. He entered at length into the numerous abuses caused by the general use of tobacco, illustrating his conclusions by cases in point. Authorities were agreed that the cause of these troubles was the excessive use of the weed, or its employment by persons who, under any circumstances, were unable to withstand its effects. The injurious results were so obvious that it was, to him, incomprehensible that medical men should indulge in so pernicious a habit, when daily reminded and fully cognizant of its evil results, and constantly reminded of them by pathological examples. The author said medical men should, in their personal conduct, their habits and their morals, be an example in the community. They should, therefore, avoid all debasing influences, as well as anything that tended to lower the esteem in which they were held by their patients. In conclusion, he drew a vivid picture of the tobacco-smoking and tobacco-chewing physician, whose person, reeking with the aroma of stale tobacco, and whose clothing, besmeared with the profuse expectoration of tobacco chewing, could hardly fail to be an object of disgust to his unfortunate patients.

DR. C. E. FOWLER said: At one time Blaine was opposed to the tariff on tobacco, from the fact that he found nearly every laboring man smoked after meals, and he had come to the conclusion that tobacco was almost an absolute necessity. The speaker confessed that he was one of the sinners. Physicians had bad habits, like other people, but he agreed with the author that, from a high moral standpoint, a physician should not indulge in the use of tobacco. It was not from the use, but rather from the abuse, of the weed that we find the conditions of nervous irritability so frequently met with.

DR. THOS. ROSS thought the paper was an exaggeration. No physician could point to a single case of death caused directly from smoking. The use of tobacco was very general, both by rich and poor, and there was certainly something in it for which the human system craved. He thought that physicians smoked from the sense of comfort that it gave; being compelled to look so much at the dark side of things, that, when tired and worried, it was quite natural to take up the pipe. Tobacco has a soothing effect which is not produced by anything else, and there is nothing that will give a man the same pleasure as a good cigar. Every one present had, no doubt, seen cases of insomnia and indigestion, due to the excessive use of tobacco, but the trouble always passes away as soon as the cause is removed.

DR. J. H. PARKINSON: I am one of the non-smokers, and have, therefore, some hesitation in criticising the paper. I do not believe that moderate indulgence in tobacco is injurious, but it can hardly be denied that tobacco smoking, and especially tobacco chewing, are dirty habits. Every man must decide for himself whether he will use tobacco, but I believe that the odor of tobacco smoke is offensive to many persons when well, and to a still larger number when sick. I certainly think that physicians should neither smoke in their offices, nor permit others to do so when it is possible to prevent it.

DR. G. A. WHITE: There is much to be said for and against the habit. People through the South use tobacco more than those residing in the Northern States. In the University of Virginia, inquiry showed that only three per cent. did not use tobacco, while in the University of Vermont not quite three per cent. used it. Personally, he had used tobacco for twenty-five years, but he had been compelled, possibly from cardiac weakness, to abstain. During the last two or three years, he had again commenced to use it. Its effects had sometimes been very unpleasant, and he remembered, on one occasion, after a meeting of the Society, where he had been unable to operate, owing to the depressing effects of over indulgence which, in his case, resembled an overdose of jaborandi. People of a phlegmatic temperament can stand much larger quantities of tobacco than others, but there are very few who can use it to any extent and escape its ravages.

Dr. D'A. Power believed that every man should use tobacco according to his own particular case. He had certainly seen deaths that were due to tobacco poisoning, the diagnosis being based upon the exclusion of all other causes. In one case, that of a man who smoked and chewed excessively, the patient had frequent attacks of syncope, and finally died of dilatation of the heart. Improvement followed when the tobacco was discontinued, but the patient finally died from congestion of the lungs. Many of the minor ills, such as atonic and nervous dyspepsia, are relieved as soon as the patient quits smoking. In some cases no harm follows because the system becomes habituated to the use of the drug. Physicians should certainly not use tobacco, for we certainly cannot expect that others will refrain from its use when we do not abstain ourselves.

Dr. H. W. Strader had used tobacco on and off for seventeen years, but had not smoked during the past three months. He thought that tobacco, like many other things, should be used with moderation. It was a stimulant and a vaso-motor sedative to the spinal nervous system. There are certain people to whom the use of tobacco is injurious. In his experience he had never been able to diagnose a case of tobacco heart, and he believed the effects of tobacco on that organ were only temporary.

Dr. W. E. Briggs: The habit of smoking is certainly repulsive, and its effects are certainly bad. With intermission he had smoked for about ten years, during which time he thought it had had but little effect upon his health. There was no question that a man was a better physician without the habit. He had seen many ill effects from the drug, most prominent amongst which was amblyopia. It had always a bad effect upon the throat and nose. Regarding the influence of tobacco upon the brain in relation to study, he did not think that this view was borne out by practical experience. In Germany smoking was almost a universal habit. He had never seen a professor or a student that did not smoke; and in view of the scientific results attained by the German nation it did not seem that this theory of its malign effects could be maintained.

Dr. M. Gardner: By far the greater amount of injury is caused by the quality of the tobacco that is used. In the navies of the European nations every sailor is allowed so much tobacco. This tobacco is a twist made from the pure leaf, and is not injurious. It could hardly be supposed that all the great powers would knowingly sanction the use of anything tending to lower the efficiency of their men.

Dr. J. R. Laine: All nations make use of some sedative or stimulant. Savages use tobacco, smoking it and inhaling the smoke. The injurious effects of tobacco must be determined by comparison. When a man's powers are impaired and he becomes decrepid, it is quite usual to blame this upon something bad. Tobacco was injurious to the speaker; even one cigar sometimes producing the characteristic symptoms of nicotine poisoning. He did not believe in physicians setting themselves up as examples in the community. The public would usually choose what they saw fit from the profession and no more.

Dr. H. L. Nichols said his experience in smoking had been limited to one cigar of moderate cost, that he had used many years ago. He was unable to use tobacco, and therefore made no virtue of abstention. He regarded it, however, as a filthy habit, and believed that it was the cause of very many injurious results.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, August 14, 1894.

George Chismore, M.D., in the Chair.

American Medical Association.—Dr. Henry Gibbons, Jr., Chairman of the Sub-Committee on Finance, as a member of the County Society's Committee on Entertainment, reported a balance of $675.15 remaining on hand.

The Plague Four Hundred Years Ago and Now.—Dr. S. S. Herrick read a paper on this subject. He exhibited to the Society a book printed at Venice in 1493, the name of the author being Alessandro Benedetto, a physician of Verona, which treated of the plague at that time. The author's paper consisted of abstracts from this ancient work, together with his comments thereon.

Benedetto believed that the causes of this malady were various, some embracing contamination of the atmosphere through the pestilential influence of the planets; the breath of a certain dragon was also mentioned. The only rational cause cited, on the authority of Galen, being the exhalations from bloody fields of battle. Regarding the means of infection, he notes, as remarkable, that woolen garments especially preserved contagion, and cites an instance of an infected feather bed which several years later caused an outbreak of the disease. Omens and signs portending to pestilence were given due prominence. Regarding treatment, he had observed that vomiting was injurious. The bowels were ordered to be kept open, manna, amongst other remedies, being recommended for that purpose. As a prophylactic, he mentions that Galen, during the plague of Rome, used a syrup prepared from vipers, in winter. It was protective to all who drank it. "The symptoms of pestilential fever" seem to present a fair clinical picture of the disease, many of the symptoms being clearly stated. The "unmistakable signs" given are tumors of the fauces, ears, axillæ and groins, which he terms carbuncles; these, coupled with loss of consciousness. On the first or second day, a rapid pulse, persistent vomiting, foul urine and jacitation were sufficient to recognize the fever beyond a reasonable doubt. Various vegetable remedies, under the titles of simples and compends, are mentioned as having proved very effective. The quotations closed with some extracts from a chapter on tumors of the axilla and groin. This subject, Benedetto parenthetically remarks, may seem foreign to the physician, because it involves surgery, but it is obvious that the patient could not be restored to health without external treatment. Free suppuration is regarded as an element of safety. In connection with poultices, the use of which he condemns, as tending to drive the poison back on the internal organs; he mentions an excellent plaster used by the Greeks, and truthfully named "septic." This was made from the root of the narcissus, beeswax and pigeon's dung. Finally, if the tumors failed to yield to various remedies and counter-irritants, the author states, resort must be had to the knife or the hot iron. Dr. Herrick, in commenting on the foregoing, observes that the status of medical knowledge at the end of the 15th century had not much advanced beyond that of A. D. 650, as represented by Paul of Ægina, nor had much been added since the time of Galen, A. D. 131. In fact,. most that had been accomplished by the schools between these periods was the preservation of the knowledge already acquired. Quoting from ancient authorities, he showed that bubonic plague had been prevalent in Lybia, Egypt and Syria at least 200 years B. C., and that this disease was similar to the epidemics which subsequently devastated Europe. There was no reasonable doubt that the malady prevailing at Hong Kong and Canton during the present year was bubonic plague. The disease had not hitherto been studied upon modern methods of precision, but analogy strongly indicates that some microbe is the cause, and the persistence of the poison is due to spores of strong vitality. The danger of infection reaching this country would lie mainly in the personal effects of the Chinese passengers, and in view of the action of this government in placing medical inspectors at European ports, it would seem proper that similar action should be taken at Hong Kong.

Dr. C. G. Kuhlman: I take this opportunity to point out certain features in connection with the so-called bubonic plague as described in this paper, and from what I ascertained in regard to it as it now exists in China, and with special reference to its relation to so-called leprosy. It was generally held that the lepers now scattered over various parts of the world, especially Europe, are pathological disseminations of the great bubonic plague epidemic which swept over every part of the earth during the thirteenth century, having been brought into Europe by the Crusaders who fled from Asia before the conquering Saracens. While it is true we are not familiar with the etiological factors concerned in either process, still, owing to the great dissimilarity in the pathology and symptomatology of the two diseases, we are, I believe, justified in assuming that there is no analogy whatsoever between them, and that the theory cannot stand scientific criticism. Leprosy ranks with syphilis, tuberculosis, and actinomycosis; it belongs to the pathological class—granulomata. It is an exceedingly chronic disseminating adeno-dermatitis confined entirely to the skin, and from all appearances commences at the distal ends of the upper extremities in the fingers and hands by a process of granulation necrosis, from whence it ascends by way of the cutaneous lymphatic system. It seems to be a disease of occupation of those who inhabit the shores bordering upon bodies of salt water and who are constantly engaged in handling salt fish. This view is held by many able physicians who have had ample opportunity to observe and to treat the malady, daily, for years. Leprosy cannot be regarded as contagious and infectious in the ordinary sense of these terms. The deep glands are not affected by leprosy, nor does it affect the various functional organs of the body. The patients die from other causes. The most we can assume for leprosy is invasion of the organism by a microbic form whose physiological products are capable of transforming the cutaneous lymphatics into granulation tissue. The pathology and symptomatology of bubonic plague present a typical picture entirely the reverse of leprosy. Here we have an entirely acute septic process with systemic invasion affecting not only the deep glands, giving rise to bubo, but also producing metastasis, malignant pustular eruptions and capillary hemorrhages, attended with fever, vomiting, purging, hematemesis, and pneumonia. While cholera has invaded Europe several times, it is very doubtful that the bubonic plague, which seems to depend upon certain emanations from the earth, most likely carbonic acid, did ever reach there, for there is no analogy between it and leprosy, either pathological or symtomatic, to justify us in assuming that the one was the outgrowth of the other.

Dr. D. W. Montgomery said he had a bubo from a patient in Hong Kong, received through the kindness of Dr. Geo. Tait, but on account of the decomposing condition of the specimen he could not stain in the cells. The plague affects the inguinal glands. Soldiers delegated for sanitary work in Hong Kong found three feet of dirt on the floors of the houses, being the accumulations of years. Regarding the "fish theory" of leprosy, the speaker did not believe there was anything whatever in it.

Dr. Herrick, in replying, said the plague is also known as the pestilential fever; it is not similar to, nor associated with, cholera.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, July 21, 1894.

The President, John F. Morse, M.D., in the Chair.

Leprosy.—Dr. D. W. Montgomery demonstrated a case of leprosy, which had kindly been placed at his disposal by Dr. Dudley Tait. The patient, a Chinaman, 25 years of age, had acquired syphilis five years ago. One year ago, an erythematous patchy rash, similar to that now existing, broke out on both sides of his face. This cleared up on the right side, but persisted, although lessened in extent, on the left side. Six months ago, it again spread, involving both sides of the face. On carefully looking over the lesion, a lepra tubercle was discovered on the margin of one of the patches on the cheek, out of which some serum was pressed. Smear preparations of this serum stained with carbolfuchsin, and bleached with nitric acid (½) showed lepra bacilli.

The President inquired whether it was a settled fact that the bacilli were the cause of leprosy?

Dr. Montgomery: It has not been scientifically settled; we only know that the bacilli are found in the tubercular form, the tubercles containing an immense number of them. They stain more easily than the tubercle bacilli. In the erythematous variety they are hard to find. I have cut section after section in such a patch and found none. In one instance, however, in 1892, Dr. Looft found them in an erythematous lepride. The bacilli were found clumped together; he considered the demonstration of their presence an absolute diagnosis.

Dr. N. Rosencranz: I have an interesting case of pemphigus lepræ, a universal pemphigus. The demonstration of the bacilli was a failure, however. The speaker asked Dr. Montgomery whether he had had success from any line of treatment, and if he had used spermine injections, which are highly spoken of.

Dr. Montgomery: I have seen the erythema disappear under the treatment, but it will do so without treatment. I have used salol, also salicylate of sodium—the latter is one of the very best drugs for lepra fever. The experience of Hanson points that way, and I have seen it act promptly when other drugs failed.

Cancrum Oris.—Dr. J. W. Williamson presented the photograph and reported a case of cancrum oris. He said: This trouble seems to be very rare here; I have never seen a case in my private practice, nor have quite a number of medical men with whom I have spoken regarding it. The patient is a girl 5 years old, an inmate of a charitable institution; concerning the child's family history and antecedents I know very little, except that she was taken, with a younger sister, from a squalid tenement in the lower part of the city. The father is in poor health and the mother is an inmate of an insane asylum. The child was brought to me about three weeks ago and was then suffering from an ulceration of the outer surface of the gums and inner surface of the cheek. This was cauterized and an antiseptic mouth-wash ordered. A week and a half later, the characteristic dusky blue spot appeared on the cheek, and two days later a slough as large as a dollar had separated from the surrounding tissues. The patient was anesthetized and the gangrenous tissues removed by the curette. The teeth were loose and the upper maxilla necrosed, the curette passing directly into the antrum. Large masses of gangrenous tissue were also removed from beneath the molar bone. After curettement the tissues were cauterized with pure carbolic acid and the opening packed with iodoform gauze. On the morning after the operation, the child was sitting up in bed playing with her toys, and calling for food. She appeared to have no pain and her mental condition was as bright as usual. Since then the edges of the opening in the cheek have been covered with red, healthy-looking granulations, but large sloughs have been dropping out of the anterior part of the temporal fossa and the child herself has pulled out several loosened teeth. Two days ago, another dusky spot appeared on the temple about half an inch behind the external canthus, and I presume the tissues in that neighborhood will be involved with the same rapidity as those lower down on the face. The literature on the subject gives a gloomy prognosis. I have read the statement that the disease is due to a specific bacillus, but Dr. Montgomery tells me he has never seen any of the cultures.[1]

Dr. Dudley Tait: I have seen a few cases occurring in children's hospitals. It is claimed that it occurs most frequently after roseola and in children of a scrofulous tendency. It is quite impossible to limit the result of the gangrene. A case came under my observation, a year or so ago, in which half the face became gangrenous, and, notwithstanding prompt measures, death resulted. I think it remarkable in this case that the bone was involved. As to the cause, I think that any necrotic condition which produces a thrombus would bring about just such a result.

Cancer of the Uterus.—Dr. H. Kreutzmann exhibited two specimens of malignant disease of the uterus in the early stages, and gave the following histories: Case I.—Mrs. R——, aged thirty, came to the Polyclinic complaining of some abdominal trouble. She had borne several children—the last, three years ago. On examination, a very peculiar-looking cervix was brought to view. There were two deep lacerations with considerable scar formation. The patient was sent to the hospital to have the scars excised and the tears united. On operating, a piece of very suspicious tissue was cut into and removed. Some slides were prepared from it by Dr. F. A. Grazer and sent to Dr. D. W. Montgomery for examination, who reported that in one of the slides he had found some nodules of epithelium in the connective tissue. This was a symptom of cancer, which ought to be acted on immediately, if the best results are to be expected. Acting upon this report the uterus was extirpated a week ago. Case II.—The second case reported was that of Mrs. R——, who came to the German Hospital, complaining of a burning pain or sensation in the womb. On examination, the uterus was found retroverted; there was also a hardening in the left broad ligament, and right at the external os was a small, warty growth. A piece of the cervix, including this growth, was excised and sent to Dr. Montgomery, who found the mucous glands dilated, and rounded, warty growths, composed of embryonic tissue, growing into the lumina of the glands. He said: "It is not possible to make an absolute diagnosis of polypoid sarcoma in such a case, but it is urgent enough in its appearance to justify a radical operation.'" From this report it was deemed best to operate, and the uterus was excised that morning. The operation was rather difficult, on account of the immobility of the uterus. The speaker said that some time ago, at the meeting of the State Medical Society, he read a paper urging an early diagnosis and operative interference in malignant diseases of the uterus; upon this rests the future of hysterectomy. If we wait until the cases are further advanced before we operate, then we are sure to get a recurrence. In his experience it was quite plain that there are too many partial operations done, and the time for a radical operation was thereby lost. A piece of the suspected tissue should be excised, examined by the microscope, and, if there was evidence of malignancy, the uterus should at once be removed *in toto*. The operation is comparatively easy, in those early stages not more difficult than the high amputation of the cervix.

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[1] This case lived a week after being reported. The sloughing occurred around the second center of gangrene, involved all the tissues on that side up to the line of the hair; both eyelids sloughed and the eye-ball was exposed. The two areas united and the entire cheeks became gangrenous. At the time of death the dusky blue color indicative of subsequent sloughing had crossed the median line of the nose and upper lip.

DR. D. W. MONTGOMERY: For convenience we may divide the cases of cancer of the cervix into three varieties: (1) The flat form. This looks like an erosion, and is often treated as such. (2) The nodular form. Nodules deep in the cervix. (3) The warty form. Warty outgrowths in the cervix. And besides this, we have a papillary form with cuboidal epithelium. Dr. Kreutzmann's case, shown to-night, is of the nodular variety, in which clinically the little circumscribed tumors can be felt below the surface. The other case shown by Dr. Kreutzmann is not so easy of determination; in fact, an unqualified diagnosis of sarcoma cannot be given; but the neoplasm is evidently so full of evil possibilities that the extirpation of the uterus was fully justifiable. The new growth consists of finger-like and club-shaped warty growths projecting into the lumen of the glands of the cervix. These warty growths consists of embryonic tissue covered with epithelium. Macroscopically they formed jelly-like softenings in the cervix, which, on being scraped, gave "cancer juice." There are several interesting forms of these papillary sarcomata in the uterus. One, operated on by Dr. von Hoffmann a couple of years ago, gave no indication previous to the operation of the real extent of the sarcomatous infiltration. The same could be said of a case operated on by Dr. Cushing, a short time ago. In both these cases the growths, microscopically, closely simulated epithelioma.

DR. DUDLEY TAIT: I would most heartily indorse the remarks made by Dr. Kreutzmann and Dr. Montgomery, if we could accept as final the microscopical results. It is very hard to be positive with the microscope; the best of men have examined healthy glands, and reported them diseased. I would say, as Dr. Shiels said, "Let us call a halt in these things," we have too many now; in surgery also it is the same. Students now discard the stethoscope and jump to the sputum.

THE PRESIDENT: I remember one case where the diagnosis by the microscope was correct. The case was one that appeared very much like cervical erosions. A piece of the cervix was sent to Dr. Montgomery who pronounced it epithelioma. The uterus was extirpated and the woman remained well for four years, when it returned, and the patient finally died from it. During these four years it had often been doubted that the diagnosis was correct. Two similar cases are now under observation; in one the uterus was removed two years ago, and in the other three years ago; and so far there has been no return of the disease. We should not accept the microscope as an absolute judge, but in connection with the clinical symptoms it is a valuable aid.

DR. MONTGOMERY: That case of the President's was a very interesting one. I will admit we may be very liable to error; we may run across a catarrhal gland that is cut off, that may give every appearance of malignancy. We must try to admit everything, simply taking it as we find it. The microscope is simply an enlargement of the field of vision, and gives us additional facts from which to draw conclusions. The wife of a well known gentleman here became ill. A piece of suspected tissue was examined, and, on finding flat epithelial cells about a blood vessel, a diagnosis of epithelioma was made, simply on the presence of the cells about a blood vessel, which we know should not have been there. The uterus was removed, or rather it was a partial operation, and for some time afterward it was doubted by some of the medical men consulted if the diagnosis was correct; but in two years there appeared an immense tumor, and the lady is now dying. The case of breast extirpation that Dr. Tait spoke of was a peculiar case, too. There might have been a mistake made as to the nature of the tumor. We all know how hard it is to diagnose between a simple degeneration of the gland, where it is not scirrhus, and true scirrhus. It would not be a strange thing to have some other man examine it and find only scar tissue. I still have the specimen and shall examine it again. Scirrhus cancer of the breast is most curious in its evolution; that is, the advancing edge is cancerous and in the center there is no cancer. The epithelium degenerates and is absorbed, leaving nothing but cicatricial tissue. I have often thought that cancer of the breast was the most striking example among carcinomata, of the way in which the epithelium will follow the laws of growth, which it was intended it should follow.

Dr. Kreutzmann: In taking out a piece of the suspected tissue for examination, it is best to remove a good-sized, wedge-shaped piece. If the piece is too small, it is almost impossible to examine it. There certainly must be some clinical symptoms or appearance of malignancy, but I would not advise a patient to wait until well-developed clinical symptoms make their appearance before operating; if so, we lose very valuable time. In the first case reported, in cutting into the cervix, I felt suspicious tissue; the idea occurred. "perhaps this is malignant." A piece examined proved it to be so, and the uterus was extirpated. We cannot say in this case that there were any clinical symptoms. I think the microscope is a most important factor in the diagnosis, and any errors seem only to point to the negative. I say again, if there is the least suspicion of malignant trouble, operate. Dr. Howard Kelley, at the Pan-American Medical Congress, urged that women should have their uteri examined, from time to time, as dentists examine the teeth.

Dr. Tait: My reasons for doubting the diagnosis in the breast case spoken of were these: 24 years ago there appeared suddenly, and without apparent cause, a painful swelling of the breasts; there was nothing there the week before. There had been several diagnoses made; at any rate, the breast was excised, and we found it to be a well-marked case of intra-mammary abscess.

Dr. Montgomery: I cannot be sure of this breast case; as I said before, I might have been mistaken, but shall go over it again and examine it carefully. I have found that if we examine tissue for cancer, by the microscope, and find it, and the surgeons operate and there is no return, they say the trouble was not malignant. A case from St. Helena was believed to be such an error, but the disease returned in time, and the woman died. We know what terrible trouble an adenoma destruens gives. A case came under my observation some seven years ago: a piece of tissue was brought to me and on examining it microscopically, I diagnosed adenoma destruens. The patient went to Boston, where Gay operated. On the second day, a frightful hemorrhage set in, but the patient recovered, and six years afterward was in good health. There was an absolute diagnosis by the microscope, the picture being faultless.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, August 6, 1894.

The President, F. Z. Bazan, M.D., in the Chair.

Dr. Stanley Stillman read a paper entitled "A Report of Three Cases of Laminectomy." [Published at p. 581.]

Dr. L. C. Lane: There has been so little done in this field of which we have record that these cases are of special interest. Six or seven years ago a man fell at Sausalito, and was thereafter partially paralyzed. He could walk if assisted. His head was in a position indicative of subluxation of the axis or atlas. It was displaced forward and rotated, and was rigidly fixed. Sensation in the lower limbs was greatly impaired, and there was some pain. He had been in this condition nearly a year when he came to me for relief. An incision was made in the median line below the occiput, and a portion of the arch of the atlas was removed—probably as much as one-fourth of the bone—besides a portion of the axis. It was not found very difficult to do. The cord was found to be pressed upon and rose up into the wound. The operation was followed by immediate relief of the disturbance in sensation and partial improvement in motion. The pain was removed. In a few days symptoms of acute encephalitis came on, and the man died in ten days or so. No autopsy was made.

Dr. C. W. Ellinwood said that he had not much to add to the report. The results were sufficiently favorable to encourage operation in compression of the cord from any cause. In each of these cases there was a marked improvement in the nutrition of the patient. The operation is classed as an innocent one. He had been gratified in getting complete primary union of the operative wounds, in spite of the fact that all three cases had bad bed-sores at the time of operation. In the case of the woman life was greatly prolonged. In the man, who died of acute tuberculosis, rapid improvement in the motor and sensory paralyses followed the operation.

Dr. R. H. Plummer said that he had had no personal experience in the operation, but from various considerations he would advise immediate operation in cases in which the cord was compressed by fracture, for delay would result in softening of the cord and render restoration impossible. The operation would add little to the danger, and would give the patient the best chance for recovery, if done early.

Dr. Basil Norris said the selection of cases has been, perhaps, the best that could have been made. There is in the paper evidence of much consideration and excellent work. And from this we have learned how much these operations do to inform the doctor, and how little they do to help the patient. Livingstone described the sensations he experienced when in the clutches of an enraged lion. He said that when he was completely exhausted and unable to make further effort, all hope had gone and fear departed with it. His only thought was of "what next?" So it is with such a patient. The hospital is, I admit, legitimate field of experiment for the surgeon, and when such a patient has just been through the trials of a serious operation, knowing that the surgeons have spared no pains, and all signs of the operation have been cleared away, hope springs; but, later, as the weeks roll on and the wished-for relief fails to come, hope departs, and fear goes with it.

Dr. A. W. Perry said that five years ago a tall boy fell on his neck, bending his head forward. There was complete paralysis and great depression. After a week there appeared an acute bed-sore, which spread rapidly. At the request of the physician, Dr. Perry removed the arches of the fifth and sixth cervical vertebræ. No improvement followed the operation. In those cases in which acute bed-sores form and show such great disorganization the tissues of the cord are so much injured that in all probability the operation is useless.

Dr. C. E. Farnum: A man fell on the curbstone, striking on the back of his head. Twenty-four hours afterward there was complete motor and sensory paralysis below the clavicle. Dr. Simpson, who had seen the case, had recognized fracture of the cervical column. Extension was applied, and the head could be kept by this means in good position. Pressure on the sixth spinous process gave crepitus. Under anesthesia, an incision was made in the median line; the laminæ on either side were moved. The arch of the sixth was completely separated from the fifth, from which a spicula of bone pressed on the cord. By making traction on the head the bodies of the sixth and seventh vertebræ could be somewhat separated. The cord was nearly divided in two. The patient died five or six hours after the operation. Personally, the speaker believed the operation was justifiable. With modern aseptic treatment the operative course is the only one to pursue in many fractures of the spine.

Dr. G. B. Somers had seen seven or eight cases of spinal injury. No attempt was made to do anything because of the lessons learned at an autopsy on a fatal case in which the cord was completely divided. Of interest in this connection is the case of a carpenter who was sent to the Railroad Hospital at Sacramento from Los Angeles, where he had been attended by a railroad surgeon. No operation was undertaken. He lay in the hospital three weeks, and was completely paraplegic. At that time Charcot's method of treatment of tabes by suspension was announced, and it was thought that similar treatment might be of benefit in this case. After the first seance there was noticed slight movements in the digits of the feet. At the end of a month the man was able to walk, and after two months he left the hospital cured. The condition was probably one of subluxation with compression of the cord.

Dr. Stillman said that as to the time of performing the operation, the best authority does not advise immediate interference. Against early operation might be urged the fact that the fragments are then freely movable, making the operation more difficult and dangerous. He would not advise operation in all cases of compression of the cord (such as the one described) in the presence of caries, but only in selected cases, where the pressure symptoms are rapidly increasing.

Dr. O. H. Hund reported "A Case of Extensive Laceration of the Pelvic Floor of Fifteen Years' Standing, Severing the Sphincter; Three Unsuccessful Attempts at Union; Ultimate Success, with Retentio Alva." [Published at p. 589.]

Dr. C. Cushing congratulated Dr. Hund on his success in one of the most difficult operations gynecologists have to do. The reason so many fail is because the circular muscle is forever trying to get away from where it ought to be. This muscle is not much thicker than cardboard, and requires a great amount of care to keep it in place. Success in the operation depends on many elements: the general health of the patient, whether she has syphilis or tuberculosis, whether she is an unmanageable woman, etc. The most rational method of repairing the perineum when the sphincter is torn through is to reproduce, as nearly as possible, the condition which existed immediately after the receipt of the tear, and then draw the parts together with sutures. With ordinary scissors a deep cut is made laterally on each side, pretty well back, through the ends of the divided muscle. A second cut is made upward along side of the vagina in the region of the remnants of the hymen. This is known as Tait's operation, or the flap-splitting operation. Of greatest importance is the previous preparation of the woman. The average woman holds in the colon an amount of feces that is something fabulous. If you give a cathartic for three or four days before the operation, the patient is almost sure to have an enormous dejection two or three days after the operation, and the work is all undone. Emmet advises beginning preparations against such a contingency at least two weeks before the day set for the operation. A good cathartic to be used contains nux vomica and aloes. In all plastic operations, in order to be fairly successful, the flaps must come together without resistance. When an elastic strain is put on tissues, sutures will cut out in 24 hours. The sphincter muscle should be paralyzed as much as possible by stretching. The bowels had best be moved soon after the operation, say on the second or third day. Let the dejection be thin, such as is produced by a seidlitz powder, every two hours on the second day. If the bowels are kept confined for 8 or 10 days, and then emptied with a purge, hard feces will be forced through the anus, tearing again the voluntary sphincter. If the one suture next the anus gives way, the woman has lost control of fluid feces, and is almost as uncomfortable as before the operation. Do not use injections into the vagina or rectum until one week after the operation. The parts should not be disturbed. It is a matter of vital importance. An excellent dressing consists of ordinary zinc ointment, to which morphin and cocain are added, in the proportion of one grain of each to the ounce. Of this, two teaspoonfuls are put in the vagina and rectum and smeared about. It lessens the pain and protects the wound edges from irritation of urine, etc.

Dr. R. W. Murphy referred to a case he had had last month in which, immediately after delivery, he put in stitches and drew the parts together. He ordered flax-seed tea for the patient in considerable quantity. The bowels moved sometimes twice a day, and the dejections were soft. He used cocain on the wounded surfaces when the stitches were being applied, and dressed with carbolized oil. The function of the sphincter was completely restored.

Dr. L. C. Lane said: While we are on this subject, in the literature on this operation you are mostly familiar with the name of Nathan Bozeman. There is a great dispute as to who was leader in the matter—Sims or Bozeman. I had the good fortune to know Bozeman. He spent a great deal of attention in the preparation of the patient. "The secret of my success," said he, "is in getting rid of the atresias." An odd way to put it, but expressive. This he did by continual stretching.

Dr. C. E. Farnum suggested, in the light of the remarks concerning the difficulty in finding the ends of the divided sphincter, that those interested in the subject dissect a badly torn perineum. One is greatly astonished to see to what great depth one must cut in order to find the severed ends of the muscle.

Dr. J. O. Hirschfelder exhibited a specimen of hemorrhagic infarction of the lung, showing the offending clot at the apex of the cone of engorgement. The case was originally one of aortic insufficiency. The left heart was hypertrophied, as was also the right, but as compensation failed, fatty degeneration took place. In the appendix of the right auricle, where the circulation must have been very slow, old coagula were found, and are to be still seen in the specimen. There was cirrhosis of the liver. The case is interesting from the number of infarcts present and from the demonstration of the cycle of changes leading up to the infarction.

SPECIAL CORRESPONDENCE.

BERLIN.

Conferring Degrees at the Berlin University.—Traditions in the Profession.—Medical Teaching in Berlin.—The Institute for Infectious Diseases.—Tuberculin as a Diagnostic and Therapeutic Agent.—Serum Therapy.—Results Obtained by Treatment.

A few days ago I attended a doctorate ceremony at the Berlin University. The candidate for his degree had already successfully passed his examination, but he had still to undergo an ordeal something like our commencement exercises. The "Dekan" of the University, von Bergmann, occupied the rostrum in his official garb, a heavy red surtout. Two conditions were quite evident: first, that comfort and ornamentation are not interchangeable (it being an exceedingly hot day); and secondly, that the surtout fitted the office and not the man, for it was evident that the coat passed from office to office without any change in its material conditions. The candidate, after presenting a series of theses in defense of his dissertation, was opposed by a physician, usually a friend of the candidate. The disputants, however, came out all right in the end, simply because the opponent had been carefully instructed what to say by his friend the candidate. Prof. von Bergmann seemed bored by this automatic ceremony, and after delivering something in Latin which was as intelligible to the auditor as the oath delivered by a police-court clerk, he handed the candidate his diploma. Thus ended a formality, which even my friend, the candidate, specified as farcical.

It is indeed strange how obsequious the medical profession is to tradition. Take as instances the presentation of theses by our graduates in medicine and the administration of the Hippocratic oath at commencement exercises. The thesis presented by the German candidate of medicine usually embodies something original, or at any rate, it serves as a medium for the report of interesting cases. Not so, the theses presented in our country. In the main they are adequate exponents of misguided plagiarism. If limited time is urged in extenuation of this countenanced literary piracy, then it is preferable to discontinue this mere formality, rather than to establish such a precedent for medical writing on the very threshold of the physician's career. One original fact, even though it be the enumeration of wrinkles on the face, is worth more than all the cumbersome articles in our medical journals, which are designed for no other purpose than the concealment of thought. The Hippocratic oath is another barbarism which should be relegated to oblivion. A few years ago, I had heard that a friend of mine, a physician, had discontinued the practice of medicine to assume charge of a quarry. I spoke to him of his apostacy, of his violation, in fact, of the Hippocratic oath, and when he demanded to know the nature of the violation, I informed him that he had sworn never to cut for stone.

Berlin, as well as Vienna, is a center of attraction for the American physician. If the prestige of a foreign medical education be the object of transatlantic migration, then let him come by all means, but if he hopes to consummate the more laudable ambition, the acquisition of medical knowledge, it will be cheaper and better for him to remain at home. It is an error to suppose that the eminent German physician consumes his time in teaching. It is an almost indisputable fact, that the German professor is a notoriously bad teacher. The fact is, that he often considers teaching a menial task which he relegates to assistants. Here in Germany, original research is the paramount ambition of every one connected with a university. Advancement is attained because the physician has achieved something in science, his didactic ability playing no role. Thus the German physician, by concentration in the direction of limited areas of research, is constantly adding to the data of scientific medicine. So relentless has this scientific inquiry become, that fields formerly regarded as limited, are so extended that the creation of new specialties can be confidently prognosticated. The hematologist will concern himself only with the pathology of the blood, the bacterio-therapeutist will only use remedies of bacteritic origin, etc.

Koch may be cited as an instance where eminence prefers the laboratory to the didactic arena. He is an honorary professor and director of the "Institute for Infectious Diseases." While all the other departments of the Berlin University serve as depots for scientific research and instruction, this institute is devoted exclusively to the furtherance of science. Here, surrounded by such eminent and earnest workers as Wasserman, Ehrlich, Pfeiffer, Cornet, and others, he is evolving a superstructure that will revolutionize modern medicine. He will create a new era in medicine that will be known as "the age of bacteria." His results are atomically accretive, and are destined to survive a mere ephemeral existence. Bacteriology is even now so closely interwoven with medicine, that success as a medical practitioner postulates a thorough knowledge of bacteriology. The Institute for Infectious Diseases is divided into a scientific and hospital department. The former consists of a bacteriological and chemical laboratory, while the hospital department has accommodations for 130 patients.

Tuberculin is extensively used at the Institute for diagnostic and for therapeutic purposes. Tuberculin is prepared by Koch from old bouillon cultures of tubercle bacilli, which have been evaporated on a water bath to $\frac{1}{10}$ their volume, and then separated from the dead bacilli by filtration. As a diagnostic agent, tuberculin serves as a delicate reaction for all tuberculous processes. Injected under the skin in 5 milligramme doses, no reaction is observed in the healthy subject. Should the individual be tuberculous, a pyrexia of many hours' duration supervenes, attended with headache, nausea, and vomiting, If the tuberculous patch is observable, redness and swelling of the same will occur. I was assured that in some cases 10 and even 15 milligrammes of tuberculin were necessary before any reaction manifested itself. They now assume that fever occurring in the course of pulmonary tuberculosis is purely accidental and due to mixed infection, namely, the presence of streptococci. In an article written nearly five years ago I maintained that the intermittent temperature and sweating in phthisis were septic processes independent of the action of the tubercle bacilli; and furthermore, that this infection emanated from the stagnant secretions in the lung caverns; that when the secretions were removed, and the cavities lavaged by arial currents as achieved by the use of the pneumatic cabinet, fever and sweats could be eliminated from the syndrome of the disease. The use of tuberculin for diagnostic purposes is not regarded with the same indifference by the medical profession in Germany. Everybody has a "little tuberculosis." That is, there may be some latent patch which is benign if left alone, but irritate it, as you no doubt will by tuberculin injections, and the previously encapsuled and inert bacilli may become disseminated, and conduce to general infection. Therapeutically, tuberculin is of signal advantage in lupus, tuberculous ulceration of the larynx, intestinal and peritoneal tuberculosis. The danger of relapse, however, is always great. Tuberculous affections of the bones and joints are apparently uninfluenced, while the results in incipient phthisis have not been definitely determined.

Serum therapy, or therapeutic immunization, as it is sometimes called, will soon figure prominently in the treatment of many infectious diseases, notably diphtheria. In order that this mode of treatment may be clearly understood by your readers, even though I commit the offense of being tautological, a certain amount of accepted knowledge must be rehearsed, which eventually culminated in the adoption of serum therapy. During epidemics, people who are not attacked enjoy what is denominated *natural immunity*. *Acquired immunity* is often secured after certain infectious diseases, like scarlatina, variola, etc., the subject usually resisting further invasions of the same disease. *Artificial immunity* had its genesis in the use of vaccine virus against variola infection. For a long period vaccination against smallpox was the only means of immunization known in human pathology, although in veterinary medicine vaccination had been successfully employed in a variety of infectious diseases. Vaccine virus is identical with the virus of variola, differing from the latter only in potency, its strength having been mitigated by its passage through the body of the cow. When Pasteur employed vaccination against anthrax and chicken cholera, he used heat as a means of diminishing the virulence of his poison, by exposing cultures of specific germs to various degrees of heat, the higher the temperature the greater the mitigation of the virus. Still other means have been adopted for graduating the virulence of the inoculating medium, such as passing electrical currents through culture media, or by the addition to the latter of chemical substances, such as carbolic acid, bichromate of potash, etc. Another decided step forward in the preparation of the inoculating medium was to filter the culture fluid, thus obtaining a filtrate which was absolutely free from bacteria. This filtrate can, by attenuation, be graduated to all degrees of virulence, and is a successful immunizing agent. The successful employment of filtered cultures demonstrated that the bacteria were not alone responsible for the effects of immunization, but that this was secured by products derived from the growing bacteria. These products could also be found in the blood of individuals who had just recovered from some infectious disease. Thus originated the latest method of securing immunization, namely, the abstraction of blood from an animal that had been inoculated artificially. At the present time, the explanation of immunity by the theories of phagocytosis and the bactericidal action of the tissue fluids have been supplanted by the theory which supposes the antidotal action to be dependent on antitoxines, products derived from the growth of bacteria. Behring and Kitasato found that if the blood taken from animals immunized against tetanus is mixed with tetanus virus outside of the body, the virus was destroyed. If, on the other hand, they injected the serum of the blood from animals immune to tetanus into animals suffering from tetanus, a disappearance of the latter affection occurred, provided the injections were used early enough. Thus far serum therapy has been used in many infectious diseases, notably in diphtheria. At the Institute the results in diphtheria with the serum treatment have been marvelous. The diphtheritic blood antitoxine is obtained from goats, these animals not only being susceptible to the diphtheritic virus, but they also show a decided resistance to the disease. The manner of obtaining the serum is a prolix process, only available in well-equipped laboratories, and as the serum will soon be placed on the market, I will not describe its mode of preparation. The results obtained with the diphtheritic and toxine solution in 220 cases of diphtheria in children, treated at various hospitals in Berlin, are as follows:

Number Treated.	Cured.	Died.	Percentage of Cures.	Of these 67 were tracheotomized with the following results:	Cured.	Died.	Percentage of Cures.
220	168	52	76.4		37	30	55.1

The foregoing statistics show very good results, but they are largely influenced by the time when treatment was commenced. With the conventional methods of treatment, the results are not measurably influenced by the time when treatment is begun. Not so with the serum therapy; if treatment is begun on the first day, cure results in 100 per cent. of the cases; if on the second day, 97 per cent.; third day, 86 per cent.; fourth day, 77 per cent.; fifth day, 56.5 per cent.

ALBERT ABRAMS.

Berlin, August 5, 1894.

LONDON.

Prof. Fraenkel's Clinic at Berlin.—The Ear Clinic of Prof. Lueae.—Schweigger and Hirschberg.—Göttingen and Marburg.—The International Medical Congress.—Overcrowding and Deficient Accommodations and Facilities.—The Vienna Clinics.—Heidelberg.—Snellen's Clinic at Utrecht.—Moorfields.

One who has spent some time under the careful instruction of a professor in a smaller German university, finds rich material in the larger clinics, and his previous training enables him to use it to the best advantage. In the Nose and Throat Clinic of Prof. B. Fraenkel, at Berlin, each student becomes, for the time, a private practitioner. Each patient, upon entering the clinic, is examined by the professor or one of his assistants, the history and proposed treatment of the case written out in full, and the handling of the case is then intrusted to some of the twenty participants in the course. This individual, alone, is responsible for the conduct of the case. Should he require consultation, he may call the professor or an assistant. Each course lasts six months, and, during this time, one becomes acquainted with the ordinary forms of nose and throat diseases, as well as seeing many of the rarer varieties.

The Ear Clinic of Prof. Lucae, and, more particularly, the vacation course given by his assistant, Dr. Jansen, are unsurpassed by any others for this branch of surgery. The operative material is enormous, and one who wishes to gain a complete knowledge of the treatment of diseases of the mastoid, frontal sinus, antrum of Highmore, and the intracranial sinuses, finds ample opportunity here. During the vacation, operative courses upon the nose and ear are given by Dr. Jansen, and, during this time, each one is permitted to do all of the minor operations many times, and occasionally one of the more important ones falls to his lot. The greatest triumph of Dr. Jansen lies in his successful treatment of the various complications of middle ear troubles, viz: sinus thrombosis, extradural abscess, choleasteatoma, etc.

In the same building with the Ear Clinic is the Eye Clinic of Prof. Schweigger, in which 10,000 cases are treated yearly. As is unfortunately the case in most of the eye clinics, the opportunities for ophthalmoscopic examination are limited; however, the visitor may become thoroughly acquainted with all the external diseases of the eye. The work in the clinic of Prof. Hirschberg, which is also in the neighborhood, is very good, and the professor, having special talent as a teacher, the visitor may spend a long time with profit. More attention is given to asepsis and antisepsis than is generally the case in eye clinics.

At the end of my term, a day was passed at the model clinic of Prof. Schmidt-Rimpler, in Göttingen. This city lies somewhat out of the beaten track of foreign medical men, but any one would be well repaid for turning aside for a short visit. Prof. Schmidt-Rimpler very kindly domonstrated his beautiful method of estimating the refraction. One of the most delightful old towns in Germany, and one comparatively little known to the globe-trotter, is Marburg, on the Lahn. In this charming little nest is a very old university, possessing a small but well-appointed eye clinic, under the direction of a most genial and agreeable gentleman, Prof. Uhthoff, one of the most distinguished of the younger ophthalmologists. He has already won for himself an enviable reputation by his works upon "Syphilis of the Brain," "Tobacco Amblyopia," and other subjects appertaining to the influence of brain and nerve lesions upon the eye. Prof. Uhthoff is a most enthusiastic teacher, and the material of his clinic, as well as of his laboratory, is at the service of all advanced students. All cases are studied here in the most scientific manner, and very valuable work is done in the clinical laboratory.

After some weeks of work in this clinic, I accepted the invitation of Prof. Uhthoff to accompany him to the International Medical Congress, at Rome. Upon this subject enough has been written, and little of interest could be added to the letters of the many American correspondents. Suffice it to say that the imperial city seems to have had a plethora of medical men or else the successors of the Cæsars are lacking in executive ability. We received the last available room in the city, and were compelled to endure many discomforts during our stay. It is questionable whether or not such general assemblages add much to the general well being or to the stock of knowledge. Italian being known to so few of the foreign visitors, the papers of the Italian members were appreciated by few save their own countrymen. Those who, like myself, understood only English and German, found it very trying to listen to so many French and Italian papers; however, after Prof. Uhthoff had read his paper, we devoted the remainder of the time to sight-seeing. The enormous crowd of visitors and the insufficient accommodations rendered the social events somewhat of a failure. The reception at the Capitol degenerated almost into a riot, and the grand banquet became a scramble. Those who attended the theatrical performance given "in honor of the congressionists," and who paid a large price for seats, seem not to have appreciated the virtues of a free admission with charges for seats. The illumination of the Colosseum and other ruins of ancient Rome was grand and impressive, and inclined one to envy Nero, who arranged his spectacles upon a grander scale. Our sight-seeing was extended to Naples and the Island of Capri, on the south, and Florence, Milan, and Genoa, on the north. At Milan, our pleasant companionship ended, Prof. Uhthoff returning to Germany and I proceeding to Vienna *via* Venice.

Vienna has long been the center of study for the specialists, and, although Berlin is now bidding for this class of patronage, Vienna will continue for many years to be the best field for this work. In the eye clinics of Prof. Fuchs, where 15,000 patients are treated yearly, the clinic rooms are so small that little opportunity is afforded for the visitor to examine patients. The main features of interest are the operations, of which there are a large number, and the delightful clinical lectures. Every one who has read Prof. Fuchs' book on the eye has been charmed by its style; but more interesting and more complete are his lectures. He is undoubtedly the most popular lecturer in this branch in Europe. A number of chairs are reserved for visitors, and all are welcomed. In the laboratory, adjoining the clinic, Dr. Dimmer holds courses upon "The Pathology of the Eye" and "Refraction." These courses are very popular, and, because of Dr. Dimmer's thorough acquaintance with English, especially valuable to Americans. Courses are also given by Prof. Fuchs' first assistant, and occasionally by that veteran teacher, Prof. Bergmeister. The latter's operative course is one of the best, but is seldom given now. Ear work may be done with Prof. Politzer, Prof. Gruber, or Dr. Urbantschitsch. The last named is an exceedingly popular teacher, and gives a fine course. He has also devoted much attention to the education of the deaf, and has demonstrated that one who is apparently totally deaf may be taught to hear loud sounds and even ordinary conversation. The courses of operations on the ear are not equal to those in Berlin and Halle.

Returning to Heidelberg, that most beautiful of all German cities, some time was spent in the eye clinics of Prof. Leber and the throat clinic of Prof. Jurasz. The excellence of these clinics and their advantages have been described in a former letter. The laboratory of the eye clinic is one of the most complete in its appointments, and especially adapted for those wishing to do independent scientific work. Through the kind offices of Prof. Leber and an American friend, Dr. Shoemaker, of Philadelphia, I was fortunate enough to receive an assistantship at the London Ophthalmic Hospital.

En route to London, a short visit was made to the clinic of Prof. Snellen, in Utrecht, Holland. The new eye hospital just completed at that place is perfect in every detail, Prof. Snellen and his assistants speak English and German fluently, but the Dutch language is used in the clinic. It is unfortunate that the field of usefulness of so great a teacher is limited by the use of a language so little known to foreigners. One may spend a few days very profitably in witnessing the operations and learning the methods of this clinic.

Moorfield's, as it is popularly known, or the London Ophthalmic Hospital, is the second in size in the world, a larger one being in St. Petersburg. The clinic is divided into three departments, each presided over by a surgeon, who serves two days a week. The surgeons have a number of assistants, who examine all the refraction and ophthalmoscopic cases. The material is very large, amounting to 30,000 cases a year. Being assistant for three surgeons, my time is occupied each day from 9:30 until 2:30, when I examine many cases. Retinoscopy seems to have reached its highest development in this clinic, and the accuracy with which astigmatism is measured is a revelation to one accustomed to other methods. Some of the more experienced assistants are able, by this method, to select the exact glass in the most complicated case. The assistants work quite independently of the chief surgeon, calling upon him only when they are in doubt, hence the position is adapted only for those who have had some previous experience. A. B. McKee, M.D.

London, September 1, 1894.

REVIEWS AND NOTICES.

The F. A. Davis Co., of Philadelphia, will shortly issue a new work on "Obstetric Surgery," by Drs. Egbert H. Grandin and Geo. W. Jarman, of the New York Maternity Hospital. The surgical side of obstetrics in relation to the newer lines of practice, made possible through asepsis and antisepsis, will be thoroughly considered. The work has been prepared from a teaching standpoint, and will be elucidated by numerous engravings and photographic plates. A companion volume, dealing with pregnancy and the physiological and pathological puerperium, is also in preparation by the same authors.

ESSENTIALS OF REFRACTION AND THE DISEASES OF THE EYE. By Edward Jackson, A.M., M.D., Professor of Diseases of the Eye in the Philadelphia Polyclinic and College for Graduates in Medicine; Attending Surgeon to the Wills Eye Hospital, etc. Part II. ESSENTIALS OF THE NOSE AND THROAT. By E. B. Gleason, S.B., M.D., Surgeon in charge of the Nose, Throat, and Ear Department of the Northern Dispensary of Philadelphia; formerly Assistant in the Nose and Throat Dispensary of the Hospital of the University of Pennsylvania; and Assistant in the Nose and Throat Department of the Union Dispensary. Saunders' Question Compends, No. 14. Second edition revised; 124 illustrations. Philadelphia: W. B. Saunders; pp. xiv-290. Price, $1.00.

That a second edition of this work has been called for so soon shows that it has found a field not well filled. The second edition has been increased by a few pages, and the subject-matter brought up to date. A surprising amount of information is contained in the 290 pages of short questions, and the concise answers to them. It is particularly adapted to the use of practitioners who occasionally are obliged to treat cases of eye, nose, or throat diseases, but who have not the time to study the more complete works upon the subjects. Students will also find the concise manner of dealing with the various subjects very helpful. There is no occasion to mention any special part of the book, as every subject is treated with care, and as far as the condensed nature of the work make it possible with clearness and precision.

ESSENTIALS OF NERVOUS DISEASES AND INSANITY; THEIR SYMPTOMS AND TREATMENT. A MANUAL FOR STUDENTS AND PRACTITIONERS. By John C. Shaw, M.D., Clinical Professor of Diseases of the Mind and Nervous System, Long Island College Hospital Medical School; Consulting Neurologist to St. Catharine's Hospital and Long Island College Hospital. Second edition, revised; 48 original illustrations; Saunders' Question Compends No. 21. Philadelphia: W. B. Saunders; pp. 194; price, $1.00.

This manual is a small 12-mo. of 190 pages, and is a second revised edition of one of Saunders' question compends. The author speaks of his book in the introduction as a primer for advanced students. Considering the scope of the work and the ground covered, it could hardly be more than that; still, the writer would seem to have made good use of the space at his command, and in the short and necessarily superficial description of the etiology, symptoms and pathology of the diseases, manages to include a good deal of information, although this is not always equally distributed among the different subjects of which he treats. The last 37 pages of the book are devoted to insanity, which is naturally treated very briefly. As a compend the book will, no doubt, suit the prevalent taste of most students, for brief and concise treatises. It contains 48 illustrations, which are fairly well executed, most of which originally and satisfactorily display the points of especial interest.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held September 5, 1894, the following physicians, having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

William P. Armstrong, San Diego; Med. Dept. Univ. Louisville, Ky., Feb. 27,'57.
Robert A. Campbell, Los Angeles; Coll. Med. Univ. Southern California, June 1,'94.
George Lee Eaton, Oakland; Vanderbilt Univ., Tennessee, Mar. 26,'94.
Luther Calvin Havice, San Diego; Jefferson Med. Coll., Pennsylvania, May 2,'93.
John Turner Higgins, Santa Clara; Med Dept. Univ. Minnesota, June 7,'94.
C. N. Hopkins, Los Angeles; Coll. Phys. and Surgs. Illinois, Mar. 29,'92.
Donald Clayton Lazier, Geyserville; Cooper Med. Coll., California, Dec. 7,'93.
M. K. McKenzie, Kern; Detroit Med. Coll., Michigan, Mar. 10,'81.
Luther Michael ,Fortuna; Med. Coll. of Ohio, Mar. 7,'84.

Thos. B. Moore, Los Angeles; Univ. Edinburgh, Scotland (M. B. and C. M.), Aug. 1,'93.
Judson Waldo Paul, Santa Clara; Bellevue Hosp. Med. Coll., New York, Mar. 30,'91.
John A. Rosenberger, Fowler; Jefferson Med. Coll., Pennsylvania, May 9,'94.
Frederic Schiller, Los Angeles; Laval Univ., Quebec, Canada, Sept. 20,'93.
William H. Smith, Los Angeles; Omaha Med. Coll., Nebraska, Mar. 25,'86.

The following application was refused: Mme. Juilly, Los Angeles.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army, from August 21 to September 20, 1894.

In accordance with the provisions of par. 1662, A. R., as amended by G. O. No. 38, series of 1890, Headquarters of the Army, Lieutenant-Colonel William D. Wolverton, Deputy Surgeon-General, Medical Director, will proceed to and inspect the Medical Department at Forts Canby and Townsend, Wash. Par. 2, S. O. 148, Dept. of the Columbia, Sept. 13, 1894.

The leave of absence for seven days granted Captain C. N. B. Macauley, Asst. Surg., in Orders, C S., Fort Wingate, N. M., is extended twenty-three days. Par. 2, S. O. 55, Dept. of Colo., Sept. 4, 1894.

Captain Walter D. McCaw, Asst. Surg., is relieved from duty at Camp near Wawona, California, and will repair without delay to the Presidio of San Francisco, California, for temporary duty and report, on his arrival, to these headquarters for further orders assigning him to duty with light batteries of the fifth Artillery on their practice march. Par. 1, S. O. 115, Dept. of Colo., Sept. 15, 1894.

Under instructions from the War Department, Captain E. C. Carter, Asst. Surg., U. S. A., is relieved from duty at Vancouver Barracks and in this department, and will report in person as soon as possible to the Commanding Officer, Fort Buford, N. D., and by letter to the Commanding General of the Department of Dakota. Par. 1, S. O. 152, Dept. of the Columbia, Sept. 19, 1894.

Leave of absence for four months, on surgeon's certificate of disability, is granted Major Washington Mathews, Surgeon.

Major John D. Hall, Surgeon, upon the arrival of Major J. C. Merrill, Surgeon, at Fort Sherman, Idaho, will be relieved, and report for duty at Madison Barracks, N. Y., relieving Major Daniel G. Caldwell, Surgeon.

The leave of absence for seven days, granted Capt. Louis Brechemin, Asst, Surg., is extended twenty-three days.

ITEMS.

Dr. W. L. Moore has moved from 997 Market street, San Francisco, Cal., to Hawthorne, Nevada.

Dr. J. D. Morris has removed from Snohomish, Wash., to Seattle, Wash., and has opened an office at 614 Oak street.

Dr. D. D. Crowley, who has been in Europe for several months, will resume practice on Tuesday, October 9th, at his office, 1068 Broadway, corner Twelfth street, Oakland. Hours, 2 to 3:30 P. M.; 7 to 8 P. M.

Occidental Medical Times.

Vol. VIII. NOVEMBER, 1894. No. 11.

AN ADDRESS

Delivered at the Fourth Annual Meeting of the California Northern District Medical Society.

By Wallace A. Briggs, M.D., President, Sacramento, Cal.

Misplaced Pregnancy, with Report of a Case.

Unlike most other diseases of women, misplaced pregnancy generally comes to the physician as an emergency, demanding prompt and radical treatment. In the vast majority of cases it first falls into the hands of the family doctor, whose duty it is not only to make a diagnosis, but not infrequently also to operate, and that on the spur of the moment. I feel, therefore, that no apology is needed in submitting to your consideration a condition which, because of its difficulties, both of diagnosis and of treatment, would seem rather to belong to the field of the specialist than to that of the general practitioner.

Mrs. B——, of fairly good previous health, 35 years of age, the mother of two children, aged 14 and 16 respectively; has had several abortions, the last about three months ago; menstruated last, December 3, 1893. Had been ailing slightly for a few days, and Wednesday morning, January 17, 1894, on getting up was seized with severe but indefinite distress in the right hypochondrium, followed by nausea and vomiting. I found her abed with a normal temperature, pulse 108, and of moderate volume and strength. I prescribed a sixteenth of morphin half hourly as necessary. This was soon followed by relief of pain, but nausea and occasional vomiting continued during the day. Craving for unwonted foods and the peculiar nausea aroused the suspicion of pregnancy. On the 29th a sanguinolent uterine discharge, which the patient regarded as menstuation, set in and continued until the 31st. She was relieved mentally but not physically. The temperature remained normal, the pain ceased, but anorexia increased daily until both foods and drinks were absolutely refused, and the urinary secretion was reduced to two ounces in the 24 hours. Entreaty and command were unavailing; resort to strategy was suggested by the fact that the patient took her medicines seemingly as a religious duty. Powders were ordered to be taken hourly with milk. The ruse worked admirably, and what promised to be a case of pernicious anorexia of pregnancy began to improve at once, and on the 10th of February seemed fully convalescent. At 3:30 P. M. of the 11th Mrs. B. was suddenly seized with violent abdominal pain, for which I was summoned in haste. I reached the bedside a half hour later and found her faint, blanched, and with a pulse barely perceptible at the wrist.

Diagnosis of rupture of tubal pregnancy was made at once and confirmed by the presence of a boggy mass in Douglas' *cul-de-sac*, and of a denser, more resistant mass on the left of the uterus and presumably in the left tube. At 5 P. M. Drs. Simmons, Huntington, and Sutliff concurred in the diagnosis and the necessity of immediate operation. As it was proposed to perform transfusion and celiotomy simultaneously another assistant was needed, and Mr. Peters, of the Railroad Hospital, was procured to administer the anesthetic. Fearing an accident from the imperfection of our apparatus for transfusion, Drs. Huntington and Sutliff injected 20 ounces of normal saline solution into the thighs, and a somewhat larger quantity into the rectum, while Dr. Simmons and myself opened the abdomen and removed the ruptured tube. A large quantity of blood, partly fluid and partly coagulated, filled the pelvis, insinuated itself between the folds of intestine and crowded them upward. The uterus was enlarged in both diameters. The right tube and ovary were normal. The patient held up unexpectedly well, her pulse improving considerably during the operation—probably on account of the saline injections. The highest temperature following the operation was 100.5° F., in consequence of a small abscess developing at the site of one of the intra-cellular injections. The stitches were removed on the eighth day, union was perfect, and the subsequent history of the case uneventful.

The ratio of misplaced to normal pregnancy is said to be, approximately, 1:500. My own observations correspond with this statement. In about 1,500 pregnancies I have seen four ectopic gestations; the first, in consultation with Dr. G. A. White, after full development in the abdominal cavity, and verified by autopsy; the second diagnosticated before rupture, treated successfully by electricity and previously reported; the third, after rupture and partial development in the broad ligament; and the fourth, at the time of rupture as reported in the present paper. If other cases have occurred in my practice they have been unrecognized. Dr. Joseph Price has had 83 misplaced pregnancies in 8,000 gestations—a ratio of 1:100, probably greatly above the normal ratio, because of his eminence as an operator and his consequently large consultation practice. In a series of 3,500 general autopsies, Formad demonstrated 35 misplaced pregnancies, which means that the physician who has seen a hundred deaths has seen a case of ectopic gestation.

The causes of misplacement of the ovum are obscure. Tait believes them to be chiefly those conditions that obstruct the lumen of the tubes and denude the tubal mucosa of its epithelium—that is, stenosis of the tubes and inflammation of their mucosa. These conditions of the uterus assuredly hinder, if they do not prevent, normal pregnancy. Why, when present in the tubes, should they favor tubal pregnancy? The obstacle that delays the progress of the ovum toward the uterus likewise delays the progress of the spermatozoa toward the ovary, and would, therefore, hinder fecundation not only in the uterus, but in the tubes also, and infection of the mucosa would seem hardly to favor those healthy and active nutritive processes so essential to impregnation. The answer to the question just propounded is to be found perhaps in the fact that enfeeblement or destruction of the vibratile epithelium of the tubes not only delays the onward movement of the ovum, but also facilitates the outward migration of the spermatozoa, and thus promotes both tubal fecundation and tubal impregnation. Martin, on the other hand, believes that fecundation, which generally takes place in the uterus, arrests the progress of the ovum—impregnation occurring at the site of fecundation. Occasionally, however, the spermatozoa make their way into the tube and there meet the ovum and fecundate it. In support of this view Martin adduces the fact that in seven cases, in which very early rupture took place, no evidence whatever of pelvic peritonitis was to be found. He concludes, therefore, that pelvic inflammation is a result and not the cause of misplaced pregnancy.

The classification of misplaced pregnancies has been the subject of considerable controversy. In obedience to considerations partly etiological, partly physiological, and partly pathological, the possibility of primary abdominal pregnancy has been denied, and the existence of ovarian pregnancy has been called in question. So far, however, the evidence seems to indicate the extreme rarity of primary abdominal pregnancy rather than its inherent impossibility. Undoubtedly the dead ovum would be digested in the peritoneal cavity, but the living fecundated ovum, like other microörganisms, might survive, and, like an independent proligerating cyst, might attach itself to surrounding structures and continue its development. Meeting of the ovum and spermatozoon, and consequent fecundation in the peritoneal cavity in any given case, might be extremely unlikely, and yet by no means impossible. Misplaced pregnancy, therefore, may be divided into primary and secondary; the primary forms may be divided into tubal, ovarian, and abdominal; tubal pregnancy may be subdivided into tubo-uterine, tubal proper, and tubo-ovarian, and the secondary forms may be divided into abdominal and intraligamentous. In the very large majority of cases misplaced pregnancy is primarily tubal. Rupture of the tube ends either in death of the fetus or in its continued growth, as one of the secondary forms of ectopic gestation, either intraligamentous or abdominal.

In a previous paper I have said that in the early months of ectopic pregnancy, we find all of the usual signs of early pregnancy modified by the absence of the fetus from the uterus, and its presence either in the tube or in the abdominal cavity. Menstruation is generally either missed or delayed, the uterus softens and enlarges, the areolæ darken, Montgomery's glands develop and the peculiar nervous symptoms of pregnancy follow. So far, perhaps, we have the clinical history of a normal pregnancy, but soon anomalous pelvic symptoms arise—recurrent uterine hemorrhage, the discharge of decidua, rectal and vesical irritation, paroxysmal pelvic pain accompanied by the evidences of inflammation and finally of internal hemorrhage. Rupture with shock and collapse may occur without previous irregular symptoms or previous indications of pregnancy.

In arriving at a diagnosis of misplaced pregnancy, three points are to be determined: the existence of pregnancy; the absence of the fetus from the uterus; its presence in an abnormal situation. Misplaced pregnancy is frequently preceded by a considerable period of sterility. In the early months before rupture it is attended by the ordinary symptoms of normal pregnancy only, or, by these symptoms plus one or more of the anomalous pelvic symptoms already mentioned. These symptoms should lead to a careful bimanual examination. The uterus will be found softened, enlarged, and displaced more or less, either laterally or anteriorly, according to the size and situation of the misplaced ovum. If pregnancy has advanced beyond the second month, however, the uterus will not be correspondingly enlarged. The sound should not be used, because its evidence of the vacuity of the uterus is untrustworthy, and because, if uterine pregnancy exists, abortion may thus be induced. Oftentimes we shall have to be content with the inference rather than the proof that the uterus is empty. This we can safely do when the development of the uterus does not correspond with the probable period of gestation, the decidua is free from chorionic villi, and there exists in the uterine appendages a rapidly growing, tender, pulsating, and elastic tumor of the proper size, which may be differentiated from hydrosalpynx, pyosalpynx, pelvic abscess, and the various pelvic neoplasms.

In the early months after rupture, in addition to the symptoms already detailed, we shall have sudden excruciating pain in one side of the pelvis, generally low down, accompanied by shock and the symptoms of acute internal hemorrhage. If rupture takes place into the peritoneal cavity, there will be the local evidences of pelvic hematocele; if into the broad ligament, the local evidences of pelvic hematoma.

In the later months we may elicit the early history of misplaced pregnancy, followed by rupture; the uterus, insufficiently developed, may be distinguished from the fetal tumor; the fetal movements and heart tones are more distinct than in utero-gestation, and the fetal members more superficial.

The differential diagnosis between tubal pregnancy and pregnancy in the rudimentary horn of a partially or completely double uterus is difficult, but unimportant, since both these conditions demand similar treatment. Pelvic neoplasms and the products of inflammation, when unassociated with pregnancy, are to be differentiated by the absence of the signs of this condition; when associated with pregnancy, by the slower growth of the neoplasms and their slighter sensibility and painfulness, by the greater diffuseness of inflammatory exudates, by the slower growth of hydro- and pyosalpynx, and by the greater continuity of their symptoms; when associated with abortion, by the differential symptoms already mentioned, and by the presence of the fetus and of chorionic villi in the uterine discharges. Retroversion, retroflexion, and lateral deviations may be differentiated by correction of the displacement, or by very thorough bimanual examination.

The prognosis of misplaced pregnancy when promptly recognized and properly treated is favorable, the death rate not exceeding 5 per cent.; when unrecognized or left to the unaided efforts of nature, it is unfavorable, the death rate reaching 65 or 70 per cent.

The treatment, like the diagnosis, may be divided into that in the early months before rupture, that in the early months after rupture, into the peritoneal cavity and into the broad ligament, and that in the later months. In the early months, before rupture, electricity has many advocates. The fetus is destroyed, preferably by the galvanic current, and its absorption left to nature. Numerous successful cases have been reported, among them one by myself. The chief objection to electricity is that it leaves the ovum as a foreign body and the possible source of subsequent trouble. As yet statistics of electrical treatment are not sufficiently large, and perhaps not sufficiently trustworthy, to enable us to pronounce a final opinion on its merits. Personally I feel that, in selected cases, a resort to electricity is certainly justifiable, particularly by those who are more familiar with electrical than with surgical *technique*. Immediate removal is preferred by the great majority of those who have most to do with these cases. Its risks are small and its results definitive. It leaves no cloud either on the patient's health or on her life. In the early months after rupture into the peritoneal cavity, immediate removal is imperative. In urgent cases the tube should be reached and tied as quickly as possible, while assistants transfuse a normal saline solution or inject it into the cellular tissue or the rectum. Seemingly desperate cases may be saved in this way.

In the early months after rupture into the broad ligament, the treatment is usually expectant. The patient should be kept perfectly quiet; pressure by sand-bags or cold by iced compresses may be applied to the abdomen, and later, when bleeding has ceased, large hot-water douches may be employed. By this treatment, in the majority of cases, the bleeding will be arrested and the blood will be absorbed. If pus forms, it produces a pelvic abscess, which should be treated as other pelvic abscesses, by vaginal incision, irrigation, and drainage. If blood accumulates from repeated hemorrhages, it may be removed in the same way, or if it extends well up in the pelvis, by abdominal incision. If the fetus survives it may be either destroyed by electricity or be permitted to continue its development to maturity.

In the later months, if the fetus is dead it should be allowed to remain, if possible, until the placental vessels have been obliterated—two or three months, if indications for interference do not sooner arise. It should then be removed, with the placenta and membranes. If the fetus be living, its development to maturity does not materially endanger the life of the mother. This should therefore be permitted, the patient being meanwhile under the closest observation. When she has reached full term, an incision should be made well beyond the median line of the side corresponding with the pregnancy, the fetal sac opened, the fetus extracted, the sac stitched to the abdominal wall, packed with iodoform gauze and kept in the most thoroughly aseptic condition until the placenta loosens and is removed.

ONE OF THE CAUSES OF FREQUENT MICTURITION IN THE FEMALE.

By N. Rosencrantz, M.D., San Francisco, Cal.

Read before the California Academy of Medicine.

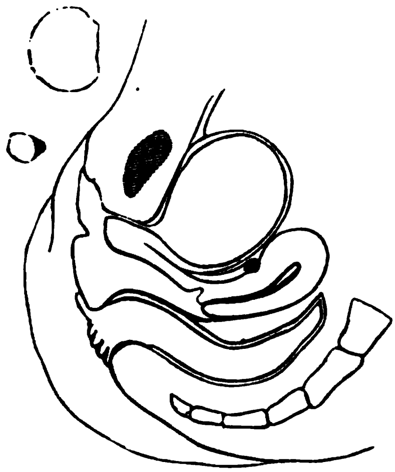
M. B——, native of Pennsylvania; æt. 46; teacher; widow, no children; has had one miscarriage; father healthy; mother died of consumption at the age of 30. Patient's health excellent until 1875, though having lived where malaria and ague were prevalent. About 1882 she experienced severe pain during the first day of a menstrual period, having, at the same time, a "desire" to urinate frequently. During the following two weeks she voided a few drops of water every few minutes. This was relieved by spirits of niter.

In 1886 she decided to undergo the "Rest Cure," but the symptom of frequent micturition did not ameliorate. During the year 1892, and up to the present time, patient would urinate almost incessantly, voiding a few drops at a time, and would always have present a "desire to pass water." During the night her sleep would be disturbed ten or fifteen times by getting up to urinate. She suffered a great deal of discomfort and vexation from the frequent passage of water. The necessity of voiding urine had grown to become very urgent, and, as a consequence, was a great source of annoyance, owing to its indelicacy. If patient was invited to visit any of her acquaintances, she would accept unwillingly and reluctantly, but would go only on one condition, and that was a *pot de chambre* would be in the adjoining room. Patient felt so miserable that life was a burden to her. She had never observed blood in the urine, and never experienced any pain.

Several irregular practitioners were consulted. One of these diagnosed Bright's disease, and ordered an antinephritic diet, and another of the learned gentlemen discovered sugar in the urine, and informed the patient daily of the percentage of glucose present. Patient suffered considerably from severe headaches. A prominent oculist ordered glasses, and said the "pain did not originate from her nose." The glasses did not relieve the pain.

On July 8, 1894, she consulted me regarding her urinary organs. She informed me of the excessive urination, and asked for immediate relief, as the symptom was unbearable and disgusting.

Examination.—Urine, sp. gr., 1015. Light amber color. No albumin or sugar present. A sound was passed into the bladder, but no calculus could be found. Cystoscopic examination was not carried out, as there was absolutely no indication for it. Examination of the vagina demonstrated a very small, immovable enlargement on the anterior surface of the uterus directly above the cervix, which was pressing upon the base of the bladder. It could not be easily determined whether the tumor had its origin from the bladder or from the uterus.



Relative position of tumor to bladder and uterus, with fibroids removed (actual size), shown above.

Upon discovering this foreign body, I at once advised her to undergo a laparotomy, which she took under consideration. Three days later patient entered German Hospital, where Dr. Max Salomon confirmed my diagnosis. July 11. After the necessary antiseptic and aseptic precautions were taken I made an exploratory incision, and, as previously mentioned, a small fibroid, the size of a marble, was enucleated from the uterus, also a very small one the size of a pea. No mishaps were experienced in the after-treatment. Patient left the hospital ten days after operation entirely cured. She now urinates five times during 24 hours. Her sleep is not disturbed, and the headaches have entirely disappeared.

46 O'Farrell street.

TENORRAPHY, WITH A REPORT OF FOUR CASES.

By T. W. Huntington, B. A., M. D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal.

Read before the California Northern District Medical Society.

The advent of clean surgery rendered reunion of tendons, severed accidentally, or divided purposely during surgical procedures, a possibility. During the long period which preceded this era, trifling injuries involving the integrity of tendons, resulted almost invariably in the permanent crippling of a limb or member. Such disability was always humiliating, and often times wholly out of proportion to the apparent importance of the lesion.

The necessity for absolutely aseptic conditions in dealing with these structures is self evident. The synovial sheaths are a favorite soil for the production of septic germs. Inflammation due to the implantation of germs runs a rapid and destructive course. Such a process not only forms a positive bar to union, but is often fatal to the life of the tendon itself.

In dealing with accidental wounds, the state of which cannot at first be definitely determined, especially when foreign matter is deposited in the tissues, it is proper to defer attempts at repair of tendon injuries until the probability of septic complications has been eliminated; a delay of two or three days, during which the wound is rendered surgically clean, in no sense complicates the more important step of tendon suture.

Tenorraphy may be done either as a primary or secondary operation; the former is of course applicable when the lesion is apparent at the time of the injury; the latter, when through inadvertence on the part of the patient or his attendant, the true state of affairs is not discovered until the lapse of a considerable period of time. The limit of time within which repair may be done, with fair prospect of success, depends upon the condition of the muscle. If through disuse it has become atrophied to a marked extent, tendon suture will barely be worth the effort. On the other hand, separation of the ends of the fragments is not an altogether discouraging feature, as I shall illustrate later on.

The *technique* of the operation is ordinarily simple. Admitting the establishment of aseptic conditions in the wound and its environments, the requirements are to uncover and approximate the cut ends and maintain apposition by the adjustment of one or more fine sutures, either of silk, chromicised gut, or what is probably superior to either, kangaroo tendon. The external wound is then closed, with adequate provision for drainage, if there be an appreciable amount of oozing. After a careful dressing has been applied, the limb should be confined upon a splint and bandaged snugly. During the following ten days, rest in bed should be strictly enjoined. To overlook this requirement is but to offer a premium for ill-success, as every contraction, whether voluntary or involuntary, of the muscle implicated retards progress and interrupts the process of repair.

The distal end of the tendon is usually located with ease, but owing to contraction of the muscle, a careful search will often be required to find the proximal end. In primary operations, the tendon sheath will form a valuable guide to the surgeon, but when considerable time has elapsed since the injury, the operator must depend in the main upon anatomical landmarks. Under the latter conditions it will be necessary to remove a section from each fragment before suturing.

When a portion of the tendon has been lost, as in some gun-shot and circular-saw injuries, approximation of the fragments without inordinate tension may be found impossible. The same difficulty is often met with during late secondary operations where permanent contraction has carried the proximal fragment far from its fellow. To obviate this difficulty and to fill in the interspace, tendon splitting has been resorted to successfully. This is accomplished by uncovering the longer, but preferably the upper and larger portion of the tendon for a sufficient distance. Then beginning at a point distant from the end a trifle farther than the length of the interspace, the knife is made to enter the tendon from its side, splitting it longitudinally to a point near its cut end. Thus a slip of tendon tissue is found attached only at the extremity; this slip or graft is then reversed, the free end being united to the distal end, thereby reëstablishing connection.

The results of this ingenious plan have been such as to meet the approval of many observers. It is even claimed that closure of such an interval by a mere shred of tendinous material is followed by a deposit of new tissue, which renders the union thoroughly secure.

The method adopted for prolongation of a contracted tendon where tenotomy is contemplated is also efficient and satisfactory. In such cases the tendon should be uncovered, and beginning at one end of the incision the knife is to be carried across its fibers to the middle point. The tendon is then split longitudinally for an inch or more according to the requirements of the case, and the remaining half of the tendon is divided at the opposite end of the incision. The affected member is then forciby extended and the ends of the two half sections of the tendon sutured in the usual manner. The subsequent management of such cases should be conducted with special reference to the maintenance of protracted extension of the parts, in order that proper alignment of the tendon may be secured during repair of the operative wound.

The following cases admirably illustrate the value of tenorraphy, as a surgical procedure:

CASE 1. O. A——, a lad of four years sustained an incised wound over the left tendo-Achilles. The skin wound was sutured by a physician who then lost sight of the case. Union of the skin was completed in a few days; about six weeks later the child was again taken to the same physician, because of serious impairment to the foot and ankle. It was then discovered that the tendo-Achilles had been severed, and that there was the interval of fully an inch between the cut ends. The case was referred to me and I determined to attempt repair of the injury. Accordingly on May 27, 1891, under ether, I made a longitudinal incision down to the tendon and readily exposed both ends; from each of which a small portion was removed with a knife. No difficulty was experienced in approximating the cut surfaces, and they were held together by two medium-sized silk sutures. The skin wound was closed and after a careful dressing had been adjusted, the limb was confined upon a posterior splint. Eight days later, union in the external wound was perfect. The child began to walk at the end of the third week, and at the present time his gait gives no intimation of any defect.

CASE 2. F. A——, æt. 35, by occupation a tailor. February 25, 1894. while standing erect in a stationary wash-bowl, the bowl gave way letting him through the bottom; at the same time he fell backward bringing the dorsal surfaces of both feet against the sharp edge of the broken porcelain. He sustained an extensive irregular lacerated skin wound, reaching across the entire right foot below the annular ligament. The dorsalis pedis artery was divided, profuse hemorrhage resulting. The ankle joint was freely opened at two points, and the following tendons were divided: the four branches of the extensor longus digitorum, the tibialis anticus, extensor proprius pollicis, and the peroneus tertius. Thus there were in the aggregate seven tendons involved in the injury. The artery was ligated immediately; three hours later ether was administered, and the various tendons reunited with silk sutures. The operation was done with the strictest regard for asepticity. The wound was healed externally at the end of a week, and the patient was allowed to move about on crutches in three weeks. One month after the injury, there was perfect voluntary movement in the ankle joint; toe motion only slightly impaired, and the general condition of the foot was excellent. Now, more than seven months from the operation, the patient walks with a firm, elastic tread, and with barely a suspicion of a limp. I fully believe, at the end of one year, he will suffer no inconvenience whatever.

CASE 3. R. C. J——, æt. 35, by occupation a machinist. September 29, 1894, was struck on the radial aspect of the right wrist by a sliver of iron in rapid motion. The radial artery and the tendons of the extensor ossis metacarpi pollicis, and the extensor primi internodii pollicis muscles were divided. My assistant, Dr. Henderson, ligated the artery and recognizing further lesions applied a temporary dressing. On the following day, I united the several tendons with fine silk, closed the skin wound, and laid the limb upon a palmar splint. This is the tenth day since the operation, the skin wound has gone on to perfect repair, and there is no doubt that union of the tendons is progressing rapidly.

The fourth and last case illustrates the method now in vogue for prolongation of contracted tendon together with tendon suture.

CASE 4. T. N——, a lad aged eleven years. For six months prior to the operation, he had been under my care on account of "griffin fingers." This condition had followed a fracture of both bones of the forearm, together with injury to important nerve trunks After exhausting my skill and ingenuity in efforts to restore the limb to usefulness, the condition of the hand remained most unsatisfactory. Voluntary flexion of the fingers was possible to a considerable degree, but extension was greatly impeded by permanent contraction of the flexor sublimis digitorum. I accordingly uncovered this tendon above the annular ligament and divided it by cutting it one-half across, then carrying the knife along its center longitudinally for an inch the section was completed. This left two attenuated portions of the tendon to be reunited in such manner as to permit of the greatest possible extension of the fingers. It would have been advisable to have treated similarly the tendons of the flexor carpi radialis, and the flexor profundus digitorum, but as the patient took ether badly, and developed alarming symptoms during the operation, further interference was out of the question. Notwithstanding these conditions the wound healed quickly and the present condition of the hand is improved to a marked extent.

In conclusion, it may be regarded as an aphorism that in primary cases, tendon suture should be an essential, routine measure, resort being had to it as often as the conditions are present. Secondary operations, however, as no positive assurance of success can be given, should, in the main, be left to the discretion of the patient or his representative.

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DIABETES MELLITUS.

By A. E. **Brune**, M.D., San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

Diabetes mellitus depends upon a disorder of nutrition, manifested by an excessive accumulation of sugar in the blood, and its continuous discharge by the kidneys. It is an independent, idiopathic disease, and must be distinguished from symptomatic diabetes, in which there is only a temporary excretion of sugar. The latter condition is usually called glycosuria, and is regarded merely as a sympton of various affections. It may be observed after ingestion of large quantities of saccharine or farinaceous food; during convalescence from infectious diseases; after poisoning with carbon oxide (illuminating gas); and is associated with great mental anxiety.

Idiopathic diabetes is a disease of comparatively infrequent occurrence. No age is exempt; it has been observed even in infancy. It, however, most commonly develops between the ages of twenty to fifty years. In regard to the real nature of the disease, many theories have been advanced, but none of them find undivided support. It is, however, generally admitted, that the disease stands in some close relation to the glycogenic function of the liver.

The presence of sugar in excess in the blood, and its excretion by the kidneys, has been theoretically explained in various ways. The following are some of the theories, supported by eminent writers:

1. That it is due to disturbance of cerebral innervation, the starting point being found in the floor of the fourth ventricle, the liver being regarded as a sugar-producing organ, under the control of the sympathetic nervous system. According to this theory, vasomotor disturbances in the hepatic circulation may result in diabetes mellitus.

2. That the function of the liver-cells may be impaired to such an extent, that they are unable to convert completely into glycogen the sugar which is conveyed to them from the food through the portal vein. It is supposed that the excess of sugar passes into the hepatic veins, and thus into the general circulation.

3. That the glycogen of the liver, instead of being stored in the liver, enters the circulation in excess, thereby producing symptoms of diabetes, and passes out with the urine, without being utilized.

4. That there is a defective assimilation of glycogen in the system; that, instead of being further converted and utilized, it remains circulating in the blood.

5. That the action of the liver being destroyed, the sugar is not

converted into glycogen, but enters the blood in such a form that it cannot undergo further changes.

No doubt, nearly every case of idiopathic diabetes can be explained by one or the other of these theories, yet not one of them gives entire satisfaction, as there is so much about the nature of the disease that remains unsolved.

There is, perhaps, no writer on this subject with such clear ideas as Dr. Voit, of Baden, formerly of Berlin, who has been, or is, himself afflicted with the disease, and who has made a life study of it. To give his ideas in a comprehensible form, it is necessary to go, to some extent, into a physiological explanation relative to the glycogenic function of the body.

We find that in the process of fermentation, starchy substances are converted into sugar, sugar into alcohol, alcohol into acetic acid and acetic acid into carbonic acid. A similar process must take place in the living organism, for we know positively that the exhaled carbonic acid is the end product of the sugar circulating in the blood, even if all stages of this transformation cannot be proven. A continuous conversion of CO_2, takes place in the cells of all the tissues in the body.

In a healthy person, the conversion of sugar into CO_2, in its various stages, goes on undisturbed and without interruption. In diabetes, however, the process goes on to a certain stage, when, in consequence of the blood having lost the quality of further converting sugar into CO_2, so that it may be exhaled, it remains circulating in the blood. Here, the sugar, for the purpose of respiration and generating heat, is lost to the system; it simply circulates in the blood as a foreign body, and, as such, is finally excreted by the kidneys.

The normal blood—no matter what nutriment has been taken—contains on an average 0.1-0.2 per cent. sugar. If this limit is passed, the excess will be excreted by the kidneys, and we then have the condition known as diabetes. The questions therefore, arise: (1) Why is the blood of diabetics overloaded with sugar? and, (2) Why is the sugar not further converted into CO_2?

Starchy substances are converted by the saliva into dextrin and sugar. The sugar then passes through the stomach into the intestines, where, by absorption, it reaches the blood in two ways: directly, by the chyle vessels, or indirectly, by the portal veins. It is very probable that nearly all of the sugar passes by way of the portal circulation; as in the thoracic duct, even after the ingestion of large quantities of saccharine food, never more than 0.1-0.2 per cent. of sugar is found.

In the liver the sugar is again converted into a substance resembling starch, differing from it only chemically, and giving a brown, reaction with iodine. This product is called liver amylum, or glycogen. From the liver, the glycogen passes through the hepatic veins into the general circulation. All the sugar conducted to the liver by the portal vein is converted into glycogen. A small quantity remains unchanged, and passes as sugar with glycogen into the general circulation.

In the blood, therefore, we find glycogen and sugar. The glycogen adheres to the white blood corpuscles, and is conveyed by them to the circulation. By the action of the blood serum, the glycogen undergoes another change. It is converted into a new form of sugar; glycogen sugar, which adapts it to undergo further decomposition: namely, combustion with the inhaled oxygen. The unchanged sugar is conveyed to the various organs and tissues of the body, particularly to the muscular structure. In the muscles, the sugar undergoes the same changes as in the liver. The glycogen is afterwards again reduced and converted into glycogen-sugar, as we have seen before in the blood, which is then ready to undergo combustion, to give off CO_2, and generate force, energy and heat, particularly during muscular activity, which brings more oxygen to the part.

The same process of partial conversion of sugar into glycogen, and of glycogen again into glycogen-sugar, seems to take place in all parts of the body where plasma formation is in progress, and cell life is active; for glycogen has been detected in nearly all the organs and tissues of the body, and sugar has been found everywhere, not only in the blood and lymph, but also in the various fluids of the system.

While the percentage of sugar in all tissues and fluids where both glycogen and sugar are found, never exceeds 0.15 per cent., we find that, under normal conditions, the percentage in the liver runs to oxygen .50 per cent. and over, proving this organ to be the principal seat of glycogenic function. Within the stated limits, the quantity of sugar in the liver varies according to the quantity and quality of the food ingested, some glycogen being found even in the starved condition up to the sixth or eighth day, when it gradually disappears. The most copious formation of glycogen in the liver occurs after the ingestion of amylaceous food, in which instance the quantity may accumulate to 10 per cent. of the weight of the liver. The more sacchariferous the food, the more glycogen is produced.

In a diabetic, the sugar disappears entirely from the urine as early as twenty-four hours after abstaining from eating, thus proving that the sugar in the urine has its origin in the food and not in the tissues of the body. It does not matter how much glycogen may be stored in the liver; the blood never contains more glycogen and sugar than 0.1 0.2 per cent. This would indicate that the white blood corpuscles, whose function it is to convey the glycogen from the liver, are under an inhibitory nervous influence, enabling them to absorb just as much glycogen in the liver as the blood demands, on the same principle as in the process of respiration, the lungs absorb only so much oxygen as the body consumes.

In proportion as the nervous influence governing these processes becomes weakened or paralyzed, the glycogenic function of the liver ceases, and the sugar passes unchanged through the portal and hepatic circulation into the general circulation. With this unconverted sugar, the blood becomes overcharged, and we have, as a result, diabetes. The longer the disease exists, and the more it develops, the more the glycogenic function of the liver becomes destroyed. This can be proven by the fact that, in the second stage of the disease, the liver-cells are without a trace of glycogen; whereas, at all other times, they are overloaded with it. Also in the same stage of the disease, the whole quantity of sugar ingested appears within one hour in the urine, which rapid transit would indicate that it has not previously been converted into glycogen.

The nervous influence appears to be of a double nature: (1) to stimulate the faculty of the liver; and, (2) The inhibitory influence to retard the action by which the white blood corpuscles are enabled to absorb just as much glycogen as the blood is in need of. If these faculties are interfered with, the blood will become overcharged with sugar, which will produce the symptoms of diabetes, and finally prove fatal to the organism.

From experiments made by Pettenkofer and Voit, it has been demonstrated that diabetics inhale less O. and exhale less CO_2 than healthy persons, facts which seem to prove, that by the presence of sugar in large quantity, the red blood corpuscles have suffered in their ability of binding O. In diabetics, therefore, in consequence of this centrally located nervous disturbance, the glycogenic function is not alone affected, but also the respiratory function; as well as the oxidation in the blood and in the tissues.

The glycogen of the blood, which cannot become sufficiently oxydized becomes deposited in the kidneys. This leads to another form of paresis in the uriniferous tubules. They become weakened, and lose all power of resistance in consequence of this continual discharge of large quantities of urine; and finally allow the sugar to escape just as the albumin in albuminuria. This want of resistance stands in close relation to the glycogenic degeneration of the uriniferous tubules, as described by Frerichs, who found it to be a constant anatomical change of diabetes.

If the foregoing physiological explanations are correct, we have then, besides the various forms of symptomatic, two forms of idiopathic diabetes, both depending on a disturbed nervous influence: a faulty nervous innervation. In one form, the nervous influence that governs the production, in the other, the influence that governs the consumption, is affected. In the first form the liver cells in their function may either be weakened or completely paralyzed. This is the most serious form of diabetes, as the glycogenic function of the liver may be entirely lost.

In the other form of diabetes, in which the inhibitory function is affected, the sugar may undergo the proper conversion into glycogen while passing through the liver, but the glycogen, instead of being stored up for gradual use, is, without impediment, permitted to enter the circulation, where it accumulates, causing morbid changes in the blood and kidneys, and is excreted with the urine without having benefited the system in the least.

The prognosis, as far as recovery is concerned, is very unfavorable, yet more favorable in that form of diabetes in which the inhibitory function alone is affected, as with proper treatment and dietetic regulations, better nutrition may be secured and maintained. To differentiate between these two forms of diabetes, the patient must be kept on a strict nitrogenous diet. If, after three days of total abstinence from carbo-hydrates, the urine still contains sugar, the liver must be still active, for the source of sugar then must come from the chemical conversion of albuminoids in that organ.

From this it appears, that idiopathic diabetes is strictly a nervous disease. It has been found that heredity plays a prominent factor in this disease—it has been observed in several successive generations. It has also been observed in families in which nervous diseases and psychopathies were hereditary. In certain cases, it is the direct effect of a nervous affection, particularly of cerebral hemorrhage, and softening, and tumors of the floor of the fourth ventricle. Functional nervous diseases, as chorea, epilepsy and psychopathies may also be associated with diabetes. It is sometimes the result of mental excitement. The disease has been attributed to injuries, particularly those which give rise to general concussion of the nervous system. I have, myself, treated a severe case of diabetes, which was the result of a blow by a sand-bag on the back of the head.

In the treatment of this disease, the main object of the practitioner must be to see that the blood at no time is burdened with sugar, so as to avoid all those unpleasant, troublesome, and dangerous symptoms that are entirely due to the mechanical influence of the sugar in the blood. He must also see that the blood always contains some saccharine matter to serve as nourishment and supply for the muscular and cellular glycogenic function; for this function will have to substitute partly the lost glycogen of the liver.

A too strict nitrogenous diet will not be beneficial. Where the liver is still active, it will lead to a breaking up of protein molecules into glycogen and urea; the latter, on account of the usual pathological changes in the kidneys, will be retained in the blood, and give rise to coma, the most dangerous, and usually fatal, symptom of diabetes. In the other form, where the liver has lost its function, the blood should not be entirely free of sugar, as it is necessary to supply the other tissues with combustible material.

Dieting should, therefore, not be too vigorously enforced. As far as medicinal agents are concerned, there is no specific for diabetes; there is no drug that has a specific action on the disease. A large number of the newer remedies, as salol, antipyrin, benzosol, sulphonal, and others, have been recommended, but have given no satisfaction in the hands of conscientious investigators.

For temporary relief, there are two that have found favor with the profession for many years past: these are mineral waters and opium. It is erroneous to expect real lasting benefit, in a chronic disease, with a tendency to weaken and enfeeble the system, from remedies which have themselves the same effect. It is not rational to treat nervous weakness with morphin, nor defective oxidation by introducing carbon into the system, as is done when mineral waters are taken in excess. The benefit derived from this treatment is only apparent—not real—as the rapid disappearance of sugar in the urine is undoubtedly due to the strict diet and hygienic measures usually enforced at the same time. The sugar generally returns as soon as the strictness of the diet is relaxed. Patients so treated may find temporary relief, but from year to year the symptoms return with greater vigor, and the weakness and emaciation increases steadily. The justification in the opium treatment lies in its slightly stimulating, and at the same time quieting, effect on the nervous system. As diabetes is etiologically a nervous disease, a quieting influence might temporarily be beneficial, but as soon as this first effect of opium has been obtained, its further use should be discontinued to avoid the debilitating narcotic effect of the drug. The occasional moderate use of alkaline mineral waters may be justifiable from the fact that the soda salts have a stimulating effect on the stomach and intestines. The alkaline waters may also serve to counteract the formation of abnormal acids in the system, to which diabetes predisposes. It is known that diabetes is an acid-forming disease, on account of a defective oxidation, associated with the same.

In late years agents have been brought into use, which, although not effecting a cure in every case, have succeeded in restoring the majority of patients to such an extent, that life, not only became bearable, but even pleasant and hopeful. This method of treatment is based on the nature and cause of the disease, which consists in a weakened or even paralyzed condition of the glycogenic function of the liver, and of the oxidation of the carbon-hydrates in the blood. This being true, the first and main object of treatment must be directed towards stimulating nervous activity, and promoting oxidation, with a view of renewing the function of the liver cells. That this can be done, even without the use of medicinal agents, except for symptomatic indications, has been demonstrated by the success obtained in country resorts, properly located, and maintained for the treatment of this class of patients. Dr. Voit, who conducts a sanitarium for diabetics in Baden-Baden, claims to be able to restore 90 per cent. of his patients.

The means employed with such wonderful results are all of a physical nature; they are rustic life, pure air, muscular activity, mental rest, cold or cool bathing, friction, massage, electricity and diet. It is the ozone in the atmosphere to which the specific action is attributed. It is considered to be the best agent for stimulating a weakened nervous system, reviving nervous action, and especially influencing the liver cells to renewed activity. An atmosphere rich in ozone-oxygen, therefore, is to be recommended to a patient. Such is best found in forests, mountainous timber-lands, or on the ocean. It is beneficial in such an atmosphere to sleep by open windows or outdoors in tents, and to combine this with moderate muscular exertion in the form of labor or hill-climbing.

While so engaged, the patient should be free from care and worry, for mental rest is essential in the treatment of all nervous affections. Cold bathing has also proved to be of great service. The bath should be taken frequently, but should be of short duration, and after bathing, friction or regular massage be employed.

The diet, for reasons already given, should not be too rigorously enforced. Not all carbo-hydrates should be forbidden, but only those that contain starch and sugar.

All carbo-hydrates, before they are converted into CO_2, have to undergo a number of successive changes. These changes are always progressive, never retrogressive, as in a chemical conversion of sugar into CO_2, the stages are always starch, sugar, alcohol, acetic acid, carbonic acid, and they are never reversed. So in a physiological conversion, whatever the successive changes may be, they, necessarily, are always progressive. Therefore, any carbo-hydrate that naturally is beyond the stage of sugar in the process of decomposition can be ingested with impunity, for it may increase the carbon in the blood, but never the sugar.

It is for this reason, that fats, although carbo-hydrates, need not be excluded from the diet of a diabetic. This is also true of sour milk, in which the milk sugar has been converted into lactic acid. In the form of sour milk, or kafir milk, an easily combustible substance may be introduced into the system, serving as a substitute for sugar. Experience also teaches that a liberal use of alcoholic drinks, of fats, of vegetable acids, or carbonic acid waters, etc., does not increase the quantity of sugar in the urine.

In conclusion, it may be said that diabetes is a chronic nervous disease, on which the various, so highly recommended remedies have little or no effect. The principal method of treatment consists in the application of physical agents, by means of which a patient may be restored to health. It is further necessary that the patient, during the time of treatment, be thoroughly educated in regard to the nature of his condition; for it depends, mainly, on himself to remain well. A patient that has once had symptoms of diabetes must always be on his guard against a return of the disease, by diet and other hygienic measures, the rest of his life.

8 Ellis street.

DELIRIUM AND DEATH FOLLOWING CATARACT EXTRACTION.

By WILBER M. SWETT, M.D., Assistant Eye, Ear and Throat Clinic, Cooper Medical College, San Francisco.

Having noticed in THE MEDICAL TIMES of August, 1894, an article on "Delirium Following Operations on the Eye," by Dr. E. Lopez, I thought it might be of interest to report a similar case.

Mr. C——, æt. 80, American, married, came to the Clinic on account of loss of sight in his right eye and failing vision in the left.

Stæt. Presens.—General appearance, fair; well nourished; lids, normal, slight dacryocystitis; conjunctiva, slightly hyperemic; sclerotic, normal; cornea, clear, arcus senilis; anterior chamber, rather shallow; iris, reacts well; lens, R., entirely opaque; L. opaque; vitreous, R, *nil;* L., clear; fundus, R, *nil*; L. normal; vision, R., motions of hand, good perception of light; L., $\frac{15}{70}$; eyeball T, normal; muscles, normal; orbit, normal; ear, otitis media sicca; nose, rhinitis hypertrophica; deflected sepum; throat, slight pharyngitis.

Diagnosis—Right eye, cataracta dura matura; left eye, cataracta dura immatura.

Prof. Barkan operated on the right eye at the patient's house, in the presence of a portion of the senior class. Patient was nervous and uncontrollable, rolling the eye about, endeavoring to close the lids; a few drops of vitreous were lost, the speculum quickly removed, the edges of the wound adjusted and the eye bandaged. During the second night patient was restless and complained of pain. The bandage was removed, and the corneal flap found everted and infiltrated. This was replaced and the wound healed. Vision at first testing was limited to motions of the hand, patient stating that there were roots before his sight (blood clots).

Protracted healing, lack of exercise and constant worry greatly impaired his physical condition. His mind became unbalanced and he gradually grew more erratic, until opiates became necessary. Delirium rapidly increased and death followed in a few days, in all about two months after the operation.

The delirium was that of persecution and was evidently due to the fear of losing his eyesight. There was no history of insanity in the family. Patient occasionally partook of alcoholic beverages, but was not addicted to their use. His wife said he had been much worried on account of pecuniary losses. Considering the history, there must have been a predisposition to mania; the operation, worry and failure of acute vision at the first testing, served to excite his imagination and banish the last trace of reason.

14 Grant avenue.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By Wallace A. Briggs, M.D., Sacramento, Cal., and

Henry Gibbons, Jr., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Ablation of Large Interstitial Uterine Fibroids by the Perineo-Recto-Vaginal Method.—Péan formulates the following conclusions regarding fibroid tumors of the uterus: (1) Every submucous and interstitial fibroid tumor of the body of the uterus should be early removed. (2) That method of removal is preferable which permits the extirpation of the tumor while removing the uterus. (3) The growth should be removed through the abdomen when it is large; through the vagina when small or of moderate size. (4) If ablation of the fibroid necessitates great mutilation of the uterus, it is advisable to entirely remove that body and its annexes. (5) Interstitial fibroid tumors which develop on the posterior wall of the uterus and invade the recto-vaginal wall, obstruct the upper part of the vagina and render vaginal hysterectomy impossible, may be removed by means of an incision through the perineum and recto-vaginal wall extending to the peritoneum. *Technique.*—Strongly seizing the perineum and the recto-vaginal wall by introducing one blade of a long and toothed forceps into the vagina and the other into the rectum, divide the tissues on a median line between the blades of the forceps. The lower part of the tumor is then exposed between the membranes of the vagina and rectum, which it has separated. Immediately bring down the tumor by means of a pair of toothed forceps, and remove it in pieces. During, and at the close of the operation, compress the most important blood vessels by forceps, which can be removed after a few minutes or a few hours, according to the size of the vessels. Place in the cavity left by the tumor a large fenestrated rubber tube and some iodoform or salol sponges fastened to the tube by strong silk thread. Complete the operation by uniting the rectal and vaginal mucous membranes by sutures separated by Florence horsehair. Remove the sponges after two or three days, and secure antisepsis by injections through the drainage tube. This operation should only be performed in those exceptional cases in which removal by the vagina is impossible. It is then preferable to the ischio-vaginal or to the sacral method.—*Gazette de Gynécologie*, August 15, 1894.

Ustiligo Maidis in Labor.—Muscular weakness of the uterus often unduly prolongs labor and necessitates surgical intervention. The remedies in general use—the introduction of bougies, intrauterine injections, electricity, the internal administration of pilocarpin, quinine, quinine and eye ergot—either fail to attain the desired end, or go beyond it, and the contractions they excite do not present the special characteristics of contractions accompanying normal labor. Ustiligo maidis is believed to possess all the good qualities of eye ergot without its disadvantages. JAMES and MITCHELL first experimented with this remedy in America in 1886, and found that the injection of 15 drops of the aqueous extract into the lymphatic gland of a frog quickened respiration and induced clonic muscular contraction. MITCHELL, ESTACHY, and LEONARD afterward used ustiligo for atony of the uterus during labor, and DORLAND employed it in 9 cases, with excellent results. He administered the aqueous extract in doses of 192.75, and sometimes gave as much as 892. a day. Its effect is felt 25 or 30 minutes after administration, and uterine contractions are progressively accentuated exactly as in normal labor. M. GROUSDEFF resorted to ustiligo in 10 cases, after the failure of other remedies, with great benefit in every case. He recommended ustiligo maidis as a harmless and efficacious oxytocic agent.—*Vratsch—Journal de Médicine de Paris*. September 16, 1894.

SURGERY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal., and

G. F. SHIELS, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

The Prevention of Adhesions after Abdominal Operations.—DR. FRITZ BAUM says that interfering adhesions have been one of the most important obstacles in abdominal surgery, and our efforts to avoid them have, so far, been in vain. Iodoform, aristol, and other drugs applied to the surface to prevent adhesions have proved inadequate. A displaced and adherent uterus can usually be freed during a laparotomy, but adhesions reform and the uterus is even more immovable than ever. In intestinal surgery adhesions are especially felt in herniotomies. These facts had so impressed the author that he began to experiment with animal structures with a view to preventing adhesions by their interposition. These structures were rendered aseptic, and were found to be soon absorbed when placed within the cavity. The first material employed consisted of catgut woven into a cloth by having one layer of thread crossing another, which procedure proved to be very tiresome, and was soon abandoned for fish bladder, which is found in the drug stores, as the so-called "gold-beaters" skin. This was more satisfactory than the catgut on account of its pliability, and from the fact that it was easily rendered aseptic. He finally adopted the peritoneum taken from a young calf immediately after being killed. These structures were prepared by keeping them in sulphuric ether for about one week, and then leaving them in absolute alcohol from 10 to 12 days before using. In experimenting upon dogs it was found that the catgut cloth had become fenestrated and partially absorbed by the eleventh day, and by the twentieth day it had entirely disappeared. The fish bladder was almost totally absorbed in from 10 to 13 days. Dr. Baum says: "The practical use of these anti-adhesive structures has been proven to me in such startling success in three laparotomies, especially with very extensive uterine adhesions, which, after being torn, never returned, the uterus being as movable after the operation as it should be physiologically, that I am convinced of their practical value."—*Journal American Medical Association*, August 11, 1894.

Operative Treatment of Gastric and Typhoid Ulcers Associated with Perforation.—MR. A. PEARCE GOULD, in opening a discussion on this subject, stated that the pathology of perforating ulcer of the stomach and duodenum was still obscure. It was common in young and anemic women of the servant class, and also in middle-aged men. It was usually single and situated on the lesser, and very rarely on the greater, curvature of the stomach. Its size was that of a sixpence or a shilling; it was of variable depth, the floor being formed either of peritoneum or possibly of a thickened area, up to the size of the palm of the hand. The symptoms for the most part were agonizing pain after eating, frequent vomiting, hematemesis, and melena. At times the patient made no complaint, and was unaware of suffering any departure from health. In truth, the symptoms were no sure guide to the extent of the disease. In the majority of cases cicatrization took place, although in 25 per cent. perforation occurred. In 85 per cent. the perforation was on the anterior aspect of the organ opening into the peritoneal cavity. He disapproved of Billroth's recommendation of timely laparotomy, excision of the ulcer, and suture of the wound, unless it was possible to establish an exact diagnosis. The surgeon's duty consisted in the prevention or arrest of peritonitis. The only hope of doing good lay in cleansing the peritoneal cavity. Hitherto too much stress had been laid on suturing the rent in the stomach, and too little on cleansing the peritoneum. The following measures should be adopted: (1) Simple washing out of the abdominal cavity. (2) Suture of the ulcer. (3) Where that was impossible, suture of the stomach to the abdominal parietes. But he could not too often repeat that the success of these cases depended upon cleansing the peritoneum. Experience alone could decide the precise period when the operation should be performed. If too long a time were allowed to elapse, the peritonitis became general and intensified. Moreover, under these circumstances masses of lymph concealed the affected parts and interfered with the cleansing of the sac. The best site for the incision was in the middle line, as this gave the best access to the whole of the abdomen, while the seat of pain was no guide to localization. First among the fluids used for flushing he placed normal salt-solution, and then boiled water. He avoided acid or toxic solutions, and used the water hot, as he found it a powerful restorative. A vital step was the systematic flushing with a large exit-tube; where practicable he sewed up the ulcer, but attributed no particular advantage to paring or excising the ulcer. The stomach might or might not be washed out. He read the notes of 6 successful cases of operation in perforating gastric ulcer. With regard to perforation in typhoid ulcers he had collected, excluding doubtful cases, 17 cases of operation with one recovery. The steps of the operation were the same as those for gastric ulcer.

DR. R. MACLAREN, of Carlisle, in operating for gastric ulcer, preferred to make his incision in the left linea semilunarius, 4 inches in length, which allowed good access to the stomach. He emphasized the point that cleansing of the peritoneum was all important. The conditions of success were system, perseverance, and a patient not on the verge of death from collapse. A detail of much importance in after-treatment was rectal feeding. Again, if the patient were much collapsed, he did not believe much in flushing. In his opinion the operative procedures in these cases were troublesome rather than difficult. Great mortality was, however, only to be expected. He mentioned a case where perforation occurred in connection with a typhoid ulcer. The only treatment adopted was that of making an incision over the cecal region and inserting a drainage-tube. The patient, although desperately ill for some time afterward, made an excellent recovery.

MR. GILBERT BARLING thought that some of the expressions of opinion with respect to these cases were too optimistic, especially so in regard to typhoid ulcers. His experience was limited to five cases. In three of these he operated; in the fourth he regretted that he had not operated; and in the fifth the patient vomited pus and passed a large quantity of pus *per anum*, but after a perilous time ultimately recovered. In one of the cases upon which he had operated recovery followed. He agreed that the less done in perforating typhoid ulcers the better.—*Lancet—Universal Medical Journal*, September, 1894.

Sterilized Catgut in a Convenient and Portable Form.—KILIANI (*Medical Record*) advises that catgut should be sterilized as follows: Dry catgut, not kept in oil, is put in absolute alcohol for 24 hours to remove all moisture, is cut off in pieces of two and three yards length, one of which is rolled on a glass rod and then put in a glass tube open at one end and with a little hole in the other, through which a short end of catgut is pulled. The glass rod is removed and the roll of catgut is in the glass tube. This tube, with its contents, is put in a second glass tube a little wider and longer, with one end open. Then the tube is put in a dry hot-air sterilizing apparatus, the temperature of which is brought within one hour up to 176° F. This is to cause evaporation of the alcohol and water. The open end is then closed by melting the glass, and the hermetically-sealed tube is put again into the sterilizing oven, the temperature of which is brought within one hour up to the course of two hours more to 140° C. (284° F.), which is kept up for a whole hour. Another hour is consumed in letting the temperature gradually sink again; then the outer tube is scratched with a file and it is ready for use. Immediately before using it, the outer tube is broken and the inner tube, with its contents, put for two minutes into the solution in which the instruments are lying. This is Reverdin's method, slightly modified as to the method in which the catgut is stored.—*Therapeutic Gazette*, August, 1894.

Sterilization of Catgut.—RÉPIN (*Révue de Thérapeutique Médico-Chirurgicale*), has found a method of sterilizing catgut by means of heat. He uses the vapor of alcohol heated to 120° C., verifying the sterilization by placing bouillon in the same tubes with the gut. If the bouillon remains clear, the gut is fit for use; but if it becomes turbid, the ligatures should be rejected, as the tubes are infected.—*Therapeutic Gazette*, September, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

The Effect of Prolonged Excessive Light on Vision.—Dr. G. L. Johnson found from a systematic examination of the vision of the workmen engaged in Salviati's glass factory a constant relationship between the duration of time, that the men were exposed to the bright light and the impairment of vision. The defect of the sight takes the form of a gradual atrophy of the optic nerve with impaired vision, and a shrinking of the visual field for white, but most for red and green. In no case did he get a history of the atrophy becoming complete, but vision sank to $\frac{20}{50}$ and $\frac{20}{70}$ in those who had been engaged at the furnaces for many years. The red, orange, violet, and ultra violet seem to be the injurious parts of the spectrum; the former showing its effects most on the retina and optic nerve; the latter on the conjunctiva and external parts. In no case where the workmen were exposed for several years to the furnace light, did their eyes escape without some permanent loss of vision, but those men whose duties were not confined to the furnace, although in the same room and exposed to an equal degree of heat, escaped more or less completely. The effect of the furnace glare is quite different to that produced by snow, or from that caused by gazing at the sun. The first mentioned being a chronic atrophy, the second being an acute form of blindness, in all probability produced by exhaustion of the visual purple, while the latter is a destructive change caused by direct coagulation and disintegration of the bacillary layer of cells. The remedy for furnace atrophy seems to be best met by covering the upper three-fourths of the side openings in the furnace with sheets of annealed spectrum blue glass, leaving room beneath for ventilation, and for the workmen to introduce and manipulate the glass. The constant use of spectrum blue spectacles or goggles serve even better, but there are practical objections to their use.—*Medical Press and Circular*, September 5, 1894.

Cases of Glaucoma of Young People.—Dr. Story reports the following cases of glaucoma: (1) Acute glaucoma after subconjunctival injection of cocain in a girl of 15. Tenotomy was made after the injection of cocain, the pupils were dilated with atropin. Two hours later acute glaucoma developed, which yielded to repeated instillation of eserin. A month later the other eye was operated upon in a similar way, eserin being instilled instead of atropin. Glaucoma supervened as before, and yielded to eserin instilled four times within an hour. (2) Chronic inflammatory glaucoma in a girl of 18. (3) Acute glaucoma in a woman of 35. (4) Chronic inflammatory glaucoma in a man of 30. (5) Chronic inflammatory, complicated with keratitis punctata, in a man of 30.

The Treatment of Hemorrhagic Glaucoma.—Dr. Bourgeron thinks the increased intra-ocular tension is secondary to the retinal hemorrhages in true hemorrhagic glaucoma, and is dependent upon disease of the vascular system. From his study of the condition the author draws the following conclusions: (1) The prognosis in true hemorrhagic glaucoma is very bad. Enucleation is often unavoidable. (2) All operations, except sclerotomy, are contraindicated. (3) Prognosis is unfavorable both for the general condition and for the local affection, The oculist should not neglect to call the attention of the family physician to the general condition of the vascular system. (4) In the hemorrhagic stage the indications are to care for the general condition, and to prevent hyperemia of the eyeball by laxatives, diuretics, diaphoretics, diet, exercise, and hydrotherapy. In the glaucomatous stage mydriatics, moist warmapplications and injections of ergotin should be used.—*Archives of Ophthalmology.*

An Operation to Correct Astigmatism.—DR. W. H. BATES, noting the fact that after operations upon the cornea, astigmatism is produced, makes the suggestion that an operation may be made to correct high degrees of this anomaly of refraction. He makes the following propositions: (1) A corneal incision lengthens the radius of curvature of that corneal meridian which is at right angles to the line of the incision, and does not flatten any other meridian. The astigmatism produced is a regular astigmatism, and is corrected by a convex cylinder at an axis parallel to the line of the incision. (2) The immediate is greater than the ultimate result. (3) The astigmatism produced is permanent in a length of time—at least a month after the cornea has healed. There may be at first 3 D of astigmatism produced. At the end of a month there may be 2 D. At the end of three months the astigmatism may still be 2 D, and this amount will be permanent. (4) The amount of astigmatism is greater the nearer the incision is to the center of the cornea. As much as 9 D can be produced. (5) Mixed astigmatism occurs: (*a*) temporarily; (*b*) with incarceration of the iris. The corneal incision should be made at right angles to the most convex meridian. The amount of correction can be regulated by the number, depth, and location of the incisions. The author reports two cases upon which he had operated with the desired result.—*Archives of Ophthalmology.*

The Use of Thiersch Flaps in Repairing Losses of Conjunctiva.—DR. H. GIFFORD has found this method of repairing loss of conjunctiva fairly successful. In cases in which the patients were unable to wear artificial eyes on account of cicatricial contractions, he was able to improve the condition so that the eyes could be worn. In an obstinate case deep incisions were made into the subconjunctival tissue, and these were firmly packed with iodoform gauze, which was left in place for 48 hours. On removing the gauze the walls of the crevices remained so widely spread apart that, after freshening the surfaces with a sharp spoon, the flaps could be adjusted with perfect accuracy, and small rolls of gauze could be introduced to hold them in place. Sufficient space was gained to allow the introduction of a very decent-looking eye. There was considerable subsequent contraction, however, and the final result, though a decided improvement, could hardly be called brilliant.—*Archives of Ophthalmology.*

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M.D., Sacramento, Cal.

Antipyrin as a Vesical Analgesic.—(*Ann. des Malad. des org. Genito-Urin.*), M. E. VIGNERON notes the frequent occurrence of smarting pains in the bladder directly after an irrigation, and when the last few drops are being expelled. He recommends the use of antipyrin in such cases, and mentioned its value, particularly in contrast to cocain in cases requiring continued use, for relief from pain. Where the bladder is not much dilated, irrigation with a 4 per cent. solution of antipyrin—10 to 20 grains in quantity is recommended. The solution is allowed to remain 10 minutes in the bladder. In dilated bladders, a ½ of 1 per cent. to a 1 per cent. solution is strong enough; the quantity, 60 to 120 grammes, being allowed to remain indefinitely in the bladder.—*Centralblatt f. Chirurgie.*

Local Applications of Guiacol.—M. Terrand reports at the Société Med. des Hôpitaux that in order to use this remedy as a local analgesic over large areas without irritating the skin, it should have added to it an equal part of glycerin, and be covered with rubber tissue to prevent evaporation. The analgesia commences at once and is established in a few hours. Should pain return it can be relieved by renewed applications. On the other hand, to obtain antithermic effects it is necessary to use the drug pure, or nearly pure, in each case, in a vehicle which can be absorbed by the skin.—*Révue de Thérapeutique Medico-Chirurgicale—American Journal of Medical Sciences*, October, 1894.

Treatment of Epithelial Cancer of the Skin by Methylin Blue.—Dr. Darier has again taken up the question of treatment of epithelioma by methyl blue. Every one knows the quasi elective action of this substance upon epithelial tissue. The author begins by freeing the ulceration surfaces of crests by aseptic sprays and poultices. If there exist on the borders thickened resistent elevations, they are touched with the galvano-cautery so as to permit the chemical elements to penetrate to the deeper layers. The cleansed surfaces are then covered with cotton, wet in a 10 per cent. solution of cocain, and are then painted with a concentrated solution of methyl blue; 1 gramme methyl blue, 5 grammes of alcohol, and 5 grammes of glycerin. All the parts colored blue are now lightly touched with a steel stylet, moistened in a 5 per cent. solution of chromic acid. A reaction producing a purple color takes place. The blue is applied for a second time, after which the surrounding parts are carefully washed to remove any excess of staining. As a dressing either poloto powder poultices or compresses wet in a weak solution of corrosive sublimate are applied to prevent the formation of crusts. This operation is repeated every second day for four or five times, and then the methyl blue is used alone. This treatment lasts from three weeks to two months in superficial epitheliomas, according to their extent. In deep forms the author has had good success from interstitial injections of methyl blue. They bring about a softening in the center of the tumor. The contents of the pocket thus formed are evacuated, and he then acts on the walls of the cavity with methyl blue and chromic acid.—*Journal Cutaneous and Genito-Urinary Diseases*, October, 1894. [The above is the method of Prof. Mösetig, of Vienna, used by him the past ten years, *vide* Medical Times, vol. v, p. 230. I have experimented with methyl violet, but am much less enthusiastic than Dr. Darier. In employing it by itself, as it is logical to do, in order to appreciate its exact value, I have usually obtained only very imperfect results, and those open to question. I believe however, that one is authorized in saying that the method can be employed when the patients will not hear of operation of a radical nature.—G. C. S.]

The Treatment of Eczema.—Malcolm Morris, in a paper read before the Dermatological Section of the British Medical Association, treats on the management of eczema. With regard to internal medication, the less the better. In an ordinary chronic eczema, when the health does not appear to be affected, he relies entirely on local treatment. In acute inflammatory lesions, antimony is of great value. Beginning with 10 to 15 minims of the wine of antimony, and repeating the dose in an hour, and if need be two hours later, then gradually reducing to six minims three times in 24 hours. With regard to local treatment, he treats every case as if it were of parasitic origin. The best remedy in dry chronic eczema, especially of seborrhcic origin, is sulphur, and next to that resorcin. He begins with 10 grains of precipitated sulphur, or of resorcin, in an ounce of zinc ointment, gradually increasing the amount of parasiticide. When the inflammation is acute, ichthyol is especially useful. When there is much discharge he washes the part with a weak solution of boracic acid, and afterward dries it with muslin bags containing starch and boracic acid, or with flour mixed with boracic acid. Crysarobin has been successful with very persistent chronic eczema of the flexures.—*Boston Medical and Surgical Journal*, October, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Therapeutics of Sea Air.—The meteorological features of sea air, though necessarily varying widely according to latitude, prevailing winds, and land conditions of shelter, have certain more or less fixed characteristics. Sea air is everywhere somewhat moist; it is generally of relatively high density; it is always more or less in motion, and it is to some extent slightly impregnated with saline particles; it is, on the whole, much more equable in temperature than inland or mountain air. As regards its physiological influence on the healthy organism, sea air is usually tonic, *i. e.*, it promotes the processes of nutrition; it is very generally a stimulant of the nervous system; but warm and moist sea air, combined with conditions of local shelter, may even be decidedly sedative in character. There seems to be some ground for believing that sea air is always more or less provocative of metabolism and tissue change in the organism. The applicability of sea air to states of disease requires careful consideration. The neurotic, the hypochondriac, the dyspeptic patient will as often receive injury as benefit from such climatic conditions. The sufferer from cutaneous diseases should, as a rule, avoid the sea. Rheumatic and gouty patients do not, as a rule, benefit by sea air. On the other hand, strumous cases often do wonderfully well at a seaside resort, especially of the brainy type; cases of impaired convalescence after serious illness or operation do well under similar conditions, provided that all acute symptoms have subsided and all grave complications have become inactive. Simple debility and anemia also usually do well at the seaside, and so do many cases of incipient or quiescent phthisis. A key to the remarkably beneficial results of sea air in struma is to be found in its property of stimulating tissue change, by which it tends to rid the organism of morbid products and to promote healthy and normal growth. The good effects in anemia and debility are due to the freshness and purity of the air, the breeziness, and the large average of sunlight. The influence on the nervous system is a much more complex question. It is a matter of common observation that in some cases the nervous system is rendered more irritable by sea air, with resulting insomnia, nervous debility, and the like; while in other cases sea air produces deep and refreshing sleep and a general sense of *bien être*. In some cases the effect of sea air is at first excitant and infrequently sedative. The safe general rule seems to be that where there is much irritability, particularly of the sort that may be termed "irritable weakness," sea air disagrees. Where the nervous system is simply torpid or debilitated, without decided irritability, sea air will often be found beneficial. Hence, sea air is contraindicated in hysteria and in most forms of insanity; it is often indicated in nervous debility, especially when due to overwork or the wear and tear of a tedious illness. In simple atony of the stomach and bowels sea air is usually beneficial but it is probable that in some cases of chronic dyspepsia sea air is injurious by stimulating the appetite before the stomach and bowels have received sufficient activity to be able to dispose of the increased amount of food consumed by the patient. The ill effect of sea air upon many chronic cutaneous diseases, especially chronic eczema, is a well established fact, and may be due to the sea winds, with more or less saline impregnation acting as irritants to the cutaneous surface. The beneficial influence in cases of incipient and quiescent phthisis is probably simply due to its tonic properties and to the fact that life at the seaside is usually conducive to habits of simple living and healthy out-door exercise, which are so important to those suffering from phthisis. The amount and stage of the disease, constitutional peculiarities, and season of the year must be taken into account in selecting for the phthisical patient either stimulating or sedative marine resorts. Another broad rule that may help in deciding for or against the seaside is the well known fact that sea air tends to aggravate all inflammatory conditions.—*Lancet*, August 11, 1894.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Bacteriotherapy of Typhoid Fever.—FRAENKEL and MANCHOT have obtained marvelous therapeutic results in the treatment of typhoid fever with injections of sterilized cultures of typhoid bacilli. The liquid employed for these injections is prepared as follows: Tubes containing sterilized bouillon made from the thymus gland are inoculated with a culture of typhoid bacilli upon agar. The tubes thus prepared remain in an autoclave for 62 hours, at a temperature of from 36° to 37° C. They are then subjected in a sand bath to a temperature of nearly 63° C. This temperature will completely sterilize the cultures. The injections are made into the gluteal regions in progressive doses. The results formulated, after treating 57 cases of typhoid fever, are as follows: A first injection of 0.5 c. c. of the fluid produced no appreciable results, but a second injection of 1 c. c. the next day produced an elevation of temperature accompanied sometimes by a chill. The third day the temperature is reduced, and on the following day this reduction is still further accentuated. At this period the temperature can be from ½ to 1 degree below that which prevailed at the beginning of the treatment. If the injections are now discontinued the temperature again commences to rise. By now injecting 2 c. c. of the sterilized culture fluid, the same phenomena are produced, but more pronounced than before. The amount of fluid injected is increased by 1 c. c. each time, and the injections are discontinued when the temperature no longer shows a tendency to rise. Under the influence of this treatment the temperature rapidly loses its continuous character, and is transformed into a remittent type of fever. The remissions are accompanied by profuse perspiration, increased diuresis, and general amelioration. Then follows a definite apyrexial state, and the patient passes into the stage of convalescence. Even though the treatment has been begun after the debut of the disease, equally good results are obtained. TH. RUMPF has obtained similar good results in the treatment of typhoid fever in 30 cases, by injecting sterilized cultures of the bacillus pyocyaneus, which are prepared and used like the cultures employed by Fränkel, Thus it would seem that the favorable influence exerted on typhoid fever can be evoked by antitoxins from other microbes.—*Semaine Médicale.*

Trigeminal Neuralgia.—BOENNERKEN (*Berl. klin. Woch.*) directs attention to dental caries as a cause of trigeminal neuralgia. While this cause is recognized, it is often difficult to detect the offending tooth. He has observed this neuralgia in many people whose teeth were apparently healthy, and not until the application of a special diagnostic measure could the caries be detected. The following is a typical case cited by way of illustration: A woman had violent paroxysms of pain in the left temporal region radiating toward the occiput. These pains persisted in spite of the administration of the usual analgesics. The patient had many carious teeth which were filled, but notwithstanding, the pain persisted. The author then had recourse to an examination of the teeth by electric light. By transillumination he observed that in all teeth in which the pulps were healthy there was a rosy reflection, whereas in the teeth which contained unhealthy pulps the reflection was obscure. By this means he was convinced that the second left molar tooth presented a less degree of transparency than the other teeth. The application of ice water to this tooth gave no pain, but upon the application of a warm dental instrument pain was felt in the left temple. He then cut down to the pulp of this tooth and found it congested. Extraction of the pulp and filling the tooth was followed by permanent relief. He has employed this means of diagnosis in other cases with equally good results.—*Semaine Médicale.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Epilepsia Luetica.—Dr. P. Kowalewsky, in a paper on this subject, differentiates between a hereditary and an acquired form of syphilitic epilepsy. The hereditary form again may occur, either as a medullary epilepsy, in consequence of a congenital weakness of the nerve-centers, which is the most frequent form, or as a cortical epilepsy. This latter form may originate from circumscript gummatous processes, in which case the course is a typical one; it may, however, also be caused by diffuse gummatous processes. In this latter event the course of the disease is indefinite, accompanied by congenital deformities. The writer is of the belief, based on his own observations, that the medullary form is the result of paternal, the cortical form of maternal infection. The cortical epilepsy produced by acquired syphilis may be divided with regard to etiology into four different forms: (1) It may be caused by solitary gummata in the cortex or the meninges. (2) By diffuse gummatous processes of the bloodvessels of the cortex and meninges. (3) By absorption of syphilitic virus during an energetic anti-syphilitic treatment. (4) By cicatricial formation taking the place of gummata, which is one of the most obstinate forms of syphilitic epilepsy. During the secondary stage of syphilis one may meet with medullary epilepsy, though not very often.—*Berliner klin. Wochenschrift—Centralblatt f. Innere med.*

Hemp Drugs and Insanity in India.—Dr. Tull-Walsh, Superintendent of the Insane Asylum at Calcutta has made the following observations concerning the influence of these drugs in the production of insanity and allied neuroses: Hemp drugs are very largely used in Bengal, smoked as gânja and churrus, drank as chang and siddhi, or eaten as mâjune. The smoking of churrus and the eating of mâjune are not very common. Among healthy persons gânja smoked alone with tobacco, or with a very small addition of datura (two or three seeds) produces a condition varying from mild exhilaration to marked intoxication. The violent intoxicating effects are less marked, or are not seen at all, in persons having a regular and wholesome supply of food. Among persons of weak mind, or with marked neurotic tendency, even a moderate quantity or only a slight excess of hemp drugs may so increase the insanity, evident or latent, as to make such persons violent, morose or melancholy, according to the neuropathy present in the first place. Adulterations, such as datura, will increase these effects, and may, even in healthy persons, produce a very violent intoxication, simulating mania, or may develop a morose, melancholy condition, terminating in dementia. These conditions are generally of short duration and the patient ultimately recovers. So common is absolute recovery that when a patient, confined in an asylum for the treatment of insanity, said to be due to the abuse of hemp drugs, does not recover within ten months, it may be concluded that these drugs were possibly only the exciting cause and that the individual was either insane previous to their use, or a latent insanity present, was roused into activity by the vitiating effects of excess of gánja, chang, etc.—*Dublin Journal of Medical Science*, July, 1894.

FORMULÆ.

By Geo. B. Somers, M. D., San Francisco, Cal.

Tuberculosis Pulmonalis. — Carasso believes that *mentha* exerts a direct bactericdal action upon the bacilli of the respiratory tract. Besides inhalations of peppermint, the following mixture is given internally:

Creasote	gm. 8.0
Alcohol	550.0
Glycerin	250.0
Chloroform	20.0
Essentia menthæ	8.0

S.—Teaspoonful every 3 hours in a half glassful of water.—*Journal American Medical Association.*

"C. C." Cough Mixture.—The following mixture is said to be largely used in the Philadelphia Hospital:

Codein sulphate	gr. ⅛
Dilute hydrocyanic acid	m ii
Spirits of chloroform	m xv
Mucilage of acacia	m xv
Syrup of wild cherry	*ad* ʒ i

—*New York Medical Journal.*

Tympanites:

Ol. terebinthinæ	ʒ i
Ol. amygdalæ dulc.	℥ ss
Tr. opii	ʒ ii
Mucil. acaciæ	℥ v
Aq. laurocerasi	℥ ss

S.—A teaspoonful every 3 to 6 hours.—*Medical Press and Circular.*

British Oil.—This preparation is extensively sold as an application to cuts, bruises and sores:

Oil turpentine	
Oil linseed	āā ℥ viii
Oil amber	
Oil juniper	āā ℥ iv
Barbadoes tar	℥ iii
Petroleum	℥ i

—*Bulletin of Pharmacy.*

Agreeable Salicylic Mixture:

Potasii acetatis	℥ ii
Acidi salicylatis	℥ ss
Syrupi limonis	℥ ii
Aq. menth. pip	℥ viii

S.—Tablespoonful every 3 hours.—*North American Practitioner.*

Flatulence. — Hartshorne prescribes:

Olei cajuputi	ʒ ss
Tinct. lavand co.	℥ ss
Mucil. acaciæ	*ad* ℥ ii

S.—Desertspoonful when necessary. *Medical Press and Circular.*

Diarrhea in Infants.—Rothe uses

Acidi carbolici	gr. ii
Bismuthi subnitratis	ʒ i
Syr. acaciæ	℥ ss
Aq. menth. pip	*ad* ℥ ii

S.—A half teaspoonful every 2 to 4 hours.—*Medical Press and Circular.*

Milk Furnished by Strauss Milk Depot.—The New York depot, supported by Mr. Nathan Strauss, furnishes baby milk after the following formula:

Sugar of milk	12 oz.
Lime water	8 oz.
Milk	1 gal.
Water	1 gal.

This mixture is pasteurized (167° F.) *Medical Record.*

Bougard's Paste.—Used in cancer:

Wheat flour	
Starch	āā ℥ i
Powdered arsenious acid	gr. viii
Red sulphide of mercury	℈ ii
Ammonium muriate	℈ ii
Corrosive sublimate	gr. iv
Zinc chloride (cryst.)	℥ i
Hot water	℥ iss

—*Journal American Medical Association.*

PUBLIC HEALTH.

By W. R. Cluness, M.A., M.D., San Francisco, Cal.

Mortality for September, 1894.—The deaths registered in 78 town districts of the State, during the month of September, in a population of 769,870, correspond to an annual rate of 14.88 a thousand, the total mortality having been 958. 143 deaths were due to zymotic diseases, giving an annual rate of 2.22 a thousand. Of these, 4 were due to diphtheria, 47 to cholera infantum, 33 to typhoid fever, 25 to diarrhea and dysentery, 10 to cerebro-spinal fever, 3 to whooping cough, 12 to croup, 5 to intermittent and remittent fevers, 0 to scarlet fever, 3 to measles, and 0 to small-pox. 216 deaths resulted from diseases of the respiratory organs, giving an annual rate of 2.36 a thousand. Of these, 145 were due to consumption, 47 to pneumonia, 20 to bronchitis, and 4 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.16 and .72, respectively. 75 deaths resulted from diseases of the heart, 12 from alcoholism, 0 from erysipelas, 28 from cancer, and 418 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 579,500, was 16.08 The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from Sacramento, the lowest from Stockton. No report from San Diego, Marysville, and several other towns of good size.

METEOROLOGY.

Summary for September.—*Temperature.*—The normal temperature of the State for September is 69.8°; the average for September, 1894, was 69.7°, a departure from normal of -0.1°. The highest monthly mean was 91.4°, at Salton, in the desert regions of San Diego county; the lowest, 52.1°, at Boca, in the mountain regions of Nevada county. The maximum temperature was 116°, on the 22d, at Volcano Springs, in the desert regions of San Diego county; the minimum, 22°, on the 28th, at Greenville, in the mountain regions of Plumas county. The greatest monthly range was 70°, at Greenville; the least, 29°, at Eureka. The absolute monthly range for the State was 94°.

Rainfall.—The normal precipitation for the State for September is 0.21 inches; the average for September, 1894, was 0.86 of an inch, a departure from the normal of +0.65 of an inch. The greatest monthly precipitation was 4 inches, at Delta; the least, 0, at various places throughout the State.

Wind.—The prevailing direction of wind was northwest.

Unusual Features.—The unusual meteorological feature of the month was the excessive rainfall on the 29th and 30th.—James A. Barwick, Director California Weather Service.

California—Tabular Statement for September, 1894.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No. of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn..........Cal.	74.0	97	50.0	------	------	------	0	0.67	------	----	----	----	S.W.	Southern Pacific Company.
Berkeley......... "	64.0	92	50.0	74.0	55.0	19.0	1	1.61	78.0	24	5	1	S.	Obs. University of California.
Colfax............ "	69.0	98	42.0	------	------	------	0	1.00	------	----	----	----	N.E.	Southern Pacific Company.
Eureka........... "	56.0	71	42.0	63.0	49.0	14.0	5	1.84	87.0	15	12	3	N.W.	Weather Bureau Dept. Agr.
Fresno........... "	74.0	102	48.0	90.0	58.0	32.0	2	0.75	40.0	27	2	1	N.W.	" " "
Medio............ "	88.0	113	66.0	------	------	------	0	0.00	------	----	----	----	W.	" " "
Los Angeles.... "	69.0	99	49.0	82.0	57.0	25.0	2	0.73	72.0	12	18	0	W.	" " "
Monterey....... "	66.0	88	44.0	------	------	------	0	0.00	------	----	----	----	S.	Southern Pacific Company.
Napa........... "	70.0	95	47.0	82.0	57.0	25.0	1	1.23	67.0	21	7	2	S.W.	Station Napa Insane Asylum.
Oakland......... "	64.0	91	49.0	74.0	54.0	20.0	3	1.66	81.0	23	6	1	W.	Chabot Observatory.
Paso Robles.... "	67.0	98	42.0	85.0	48.0	37.0	2	1.13	37.0	28	0	2	S.W.	Southern Pacific Company.
Red Bluff....... "	75.0	100	48.0	88.0	62.0	26.0	2	1.11	40.0	25	3	2	N.	Weather Bureau Dept. Agr.
Sacramento. ... "	64.0	90	38.0	80.0	48.0	32.0	2	0.68	49.0	26	3	1	N.W.	" " "
San Bernardino "	70.0	99	42.0	88.0	53.0	35.0	1	0.37	------	----	----	----	------	A. K. Johnson, M. D
San Diego....... "	66.0	90	52.0	74.0	60.0	11.0	1	0.01	80.0	21	0	9	N.W.	Weather Bureau Dept. Agr.
San Francisco.. "	63.5	94	49.0	71.0	56.0	15.0	2	1.05	76.0	22	7	1	S.W.	" " "
Santa Barbara.. "	66.0	94	50.0	74.0	58.0	16.0	2	1.36	73.0	18	6	6	W.	Hugh D. Vail.
Santa Cruz...... "	65.0	98	44.0	78.0	51.0	27.0	2	2.77	------	21	2	7	W.	W. R. Springer.
Yuma...........A. T.	83.0	109	50.0	99.0	68.0	31.0	1	0.51	46.0	26	3	1	N.E.	Weather Bureau Dept. Agr.

Humidity at Paso Robles is the mean at 2 P. M.

Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate th text, illustrations will be furnished without cost to the author.

SACRAMENTO: NOVEMBER, 1894

OLIVER WENDELL HOLMES.

At his country seat, near Boston, there died, October 7, 1894, a man who was conspicuous in two hemispheres as having filled a dual role for nearly half a century, in each attaining eminence and renown. Only such power of concentration of thought and diversity of genius as were nature's gifts to OLIVER WENDELL HOLMES made possible a career that has proven a rich legacy to medical science and intelligent humanity.

DR. HOLMES was born in Cambridge, Mass., August 20, 1809. The house in which he first saw the light of day was but a stone's throw from the classic halls of Harvard University, and, until a very recent day, it was one of the cherished landmarks of its locality. Springing from an intellectual family, it was natural that he became at an early age an aspirant for university honors. He was graduated at Harvard in the class which stands to-day as the most remarkable in the history of that institution.

A brief period subsequent to his graduation was devoted to the study of law. Discovering for himself his lack of interest in this avocation, he abandoned it, and turned at once, and with wonderful avidity, to the field of medicine. The years 1834, 1835 and 1836 were devoted to the acquirement of his medical degree. A considerable portion of this period was spent in Paris, then the world's center of medical education. Here he became the disciple of a coterie of men, teachers of medicine and surgery, than which no other is more notable in the entire history of medicine.

In his essay, "Some of My Early Teachers," he was afforded ample opportunity, in a manner delightful and peculiarly his own, of paying tribute to some of the professors famous in Paris while he was a student in the École de Médecine. Briefly he tells of BARON BOYER, "that bent old man who is groping his way through the wards of La Charitè;" of BARON DUPUYTREN, the master surgeon of his day, whose reign no man disputed, whose supremacy some envied; of LISFRANC, the great drawer of blood and hewer of limbs; and of BARON LARREY, NAPOLEON'S favorite surgeon. "To go round the Hôtel des Invalides with LARREY was to live over the campaigns of NAPOLEON, to look on the sun of Austerlitz, to hear the cannons of Marengo; to struggle through the icy waters of the Beresina, to shiver in the snows of the Russian retreat, and to gaze through the battle smoke upon the last charge of the red lancers upon the redder field of Waterloo."

HOLMES' medical teachers were not less worthy of mention than were those whose time was devoted to surgery. He makes mention of BROUSSAIS and ANDRAL, the former a fiery exponent of old theories; but his special object of reverence was the immortal LOUIS, who first taught the necessity of numerical records and mathematical analyses in estimating the value of methods adapted to the treatment of disease.

In 1838 he was elected to the chair of anatomy and physiology in Dartmouth College. In this station he entered upon what he ever after regarded as his life's work. Nine years later he succeeded DR. JOHN C. WARREN as Professor of Anatomy and Physiology in the medical department of Harvard University. Some years after this, a special instructor in physiology having been provided, his entire attention was directed to anatomy. His resignation was tendered to the regents of Harvard University in 1882, when he was in his seventy-third year. Thus he was actively and continuously engaged as a medical teacher for forty-four years.

It is worthy of note that, in spite of his well-earned and brilliant reputation as a philosopher, essayist and poet, he was forever loyal to his first love. He was always, and upon all occasions, a doctor; and not infrequently did he emphasize his fealty to his chosen calling by statements to the end that he who would devote himself successfully to authorship should first be trained to a vocation which should occupy a portion of his time, and contribute, in some measure, to his support.

We recall with wonderful vividness, and always with tender affection, the form and features of PROFESSOR HOLMES as he appeared in the amphitheater nearly a decade before his retirement. Of medium stature and slender mold, his suit of somber black and close-fitting skull cap conveyed to the observer an impression of undue attenuation. His smoothly shaven face bore here and there apparent evidences of advancing age, but when he had fallen into a humorous vein, what had seemed wrinkles became a wreath of smiles. His countenance, usually grave, at times almost severe, was lighted up by eyes that sparkled and seemed never to rest. To his pupils he was always the same: dignified, sincere, cheery, helpful. He was indeed a dull and unappreciative listener who failed to be impressed by DR. HOLMES' charm of manner, keen wit and incomparable diction. We fancy that few students in those days parted company with their professor of anatomy with feelings other than of sorrowful regret. If, perchance, there be a few who deny to him the name and fame of a profound anatomist, to them let it be said, that in the hearts and affections of his pupils he is cherished as one of the great teachers of anatomy of the present century.

In the field of medical authorship, PROFESSOR HOLMES occupied a prominent and distinguished place. His contributions in this department were usually in the form of lectures and essays, many of them having been prepared for, and delivered upon, special occasions. Through them all there is discovered that peculiar vein of humor which has made all of his productions attractive. His monograph entitled, "The Contagiousness of Puerperal Fever," first published in 1843, attracted much attention, and there can be no doubt that it had a marked influence in the production of a radical reform in the conduct of the lying-in chamber.

The last twelve years of his life were passed quietly. A brief but memorable visit to Europe was made in 1886, during which he gathered material for that delightful volume, "One hundred Days in Europe." His time was chiefly devoted to rounding up his former literary work. Many of his productions were revised for republication, and several new volumes added to the list.

His life was full of work, and his work was a blessing to mankind. His name now passes into history as the last segment of that wonderful literary circle—LONGFELLOW, BRYANT, LOWELL, EMERSON, WHITTIER, HOLMES.

THE MEETING OF THE CALIFORNIA NORTHERN DISTRICT MEDICAL SOCIETY.

It is usual, if not always truthful, to speak of medical society meetings as "successful," and the term becomes stereotyped; yet the fourth annual meeting of the California Northern District Medical Society was so remarkably successful that the familiar term can be applied in an unqualified manner. We have attended many society meetings, but none at which more interest was evinced, nor any where strict attention and earnest work were more markedly exhibited. The entire proceedings were characterized by a vim that was positively refreshing, and that, if maintained, will place this Society in the front rank of our professional organizations. It is in all things true that that most easily obtained is least valued. The truth of the converse was here demonstrable. Men who had made long journeys, and who had sacrificed a night's rest to be present, were prepared to enter thoroughly into the spirit of the occasion. Even the President was not afraid to face a 57-mile drive in order that he might be present at least during two sessions. The total number in attendance was nearly 75, representing 30 per cent. of the membership.

As will be seen by our report of the proceedings, a number of good, practical papers were presented, and in the very full discussions following their reading, the daily experience of men, compelled to rely largely on their own resources, imparted special value to this feature. Country practice does not admit of theory or rash experiment; it demands assured methods, prompt relief from urgent symptoms, and good judgment in grave emergencies. Papers and discussions at such a gathering are, therefore, earnest and practical, results rather than speculation and inference being the rule. In the discussions on papers at the meetings of this Society, steady improvement is noticeable. Meetings of this character are of the utmost benefit to men who practise in comparative isolation, affording them an opportunity for interchange of thought and experience, without prolonged absence from business. Nothing can more forcibly testify to this than the steady increase in membership and the very large attendance at this meeting. The success of such a society is already assured; it needs only good management and fair executive ability in its officers to attain the very highest measure.

The District Society as originally organized included only five of the northern counties, but the interest manifested in its proceedings convinced its founders that a wider sphere was possible. The meeting in Sacramento inaugurated the new departure, and the large accession of members on that occasion demonstrated the correctness of this view. In accepting the invitation of the San Joaquin County Medical Society to meet in Stockton, a new territory will be invaded. We anticipate another large accession of members in this field, rendering the Society more thoroughly representative of Northern and Central California. DR. H. D. LAWHEAD, of Woodland, has been elected President for the ensuing year. DR. LAWHEAD has always been an earnest worker and a sincere supporter of medical organizations, and as he will give his best energies to this office, the Society may look for a prosperous year.

Marysville, the birthplace of the Society, is centrally located and easy of access; arrangements could therefore be made that would enable all who attended the meeting to remain until late in the evening. The banquet tendered by the Medical Society of Yuba and Sutter counties was therefore a gratifying success, and the fourth annual meeting will long be remembered as a most profitable and enjoyable occasion.

NOTES.

Dr. M. Gardner.

Mr. J. R. Foster having resigned the position of Superintendent and Secretary of the Southern Pacific Company's Hospital Association, Dr. M. Gardner, of Sacramento, has been appointed Chief Surgeon and Superintendent, with headquarters at the general office of the company in San Francisco. This appointment went into effect October 15, 1894.

The Indian Medical Congress.

The first Indian Medical Congress, which is to open in Calcutta on December 24, is beginning, our correspondent in London writes, to excite a considerable amount of interest among the medical profession in this country, and not a few, express the intention to take advantage of special facilities which are likely to be given, in order to pay the cold weather visit to India, which has now become so popular, not to say fashionable. A committee has been appointed in Calcutta to make arrangements for the convenience of foreign visitors. The price of accommodation in Calcutta may be taken to be from rupees 7 to rupees 14 a day for Europeans; the secretary for European or American visitors is Surgeon-Capt. Pilgrim, General Hospital, Calcutta. The general secretaries of the Congress are Dr. W. J. Simpson, Medical Officer of Health, for Calcutta and Dr. D. M. Moir. The Congress will be held at the time of the year when the climate of Calcutta is very agreeable; and it will be the first occasion upon which the official and non-official members of the medical profession in India will have met together upon an equal footing for the discussion of scientific questions. The Congress, according to precedent, is divided into sections as follows: 1. Medicine and Pathology. 2. Surgery, including Ophthalmology. 3. Obstetrics, and Diseases of Women and Children. 4. Public Health. 5. Medico-Legal Medicine and Insanity. 6. Pharmacology, specially Indigenous Drugs. Subjects of discussion have been suggested in all the sections, bearing more or less directly upon Eastern matters; but in the section of pharmacology special attention will be given to indigenous drugs.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, September 18, 1894.

H. L. NICHOLS, M.D., in the Chair.

Fracture at the Elbow Joint.—DR. W. H. BALDWIN reported the case of a boy [patient exhibited] 7 years of age, who fell from a fence, fracturing the epicondyle of the right humerus. Examination showed considerable tumefaction on the inner side of the arm and an abrasion of the skin. Upon movement of the elbow, crepitation was elicited. His arm was put up in the straight position; and the first dressing was removed on the eighth day, when passive motion was set up. The limb was then placed on a right angle splint. Most authorities oppose too frequent movement of the arm. In these cases malpractice suits were not unknown, the result even of careful treatment being sometimes bad. The child had since been chloroformed four times, and the joint forcibly extended. He is now carrying an eight-pound dumb-bell. There is yet some stiffness, but the time—eight weeks—that has elapsed since the injury, has hardly been sufficient to restore full motion.

DR. T. W. HUNTINGTON, who had seen the case, believed that, with the amount of motion present at the end of eight weeks, the boy would regain the use of his arm in a year. Authorities were divided as to the proper position for this fracture. He preferred to place the arm at a right angle, and in the present case would have followed the same plan that had been pursued by Dr. Baldwin.

DR. THOS. ROSS: Fractures about the elbow or knee joints are the most difficult to treat. Irregular bandaging was more likely to cause trouble than tight bandaging. Where the pressure was equally divided no harm would ensue.

DR. G. A. WHITE: If the arm be placed in the rectangular position, with the thumb upward, the bones are nearly parallel. He did not believe in interfering with the joint until repair had been so far advanced that tolerably firm union was present. The results of passive motion were then much more satisfactory.

DR. W. A. BRIGGS believed that Dr. Baldwin would get a satisfactory result in this case. He treated these injuries by placing the arm in the right angle position, and he did not begin passive motion before the eighth day.

DR. J. H. PARKINSON: The best position for this, as for all other fractures, is that in which the parts are maintained in their normal relation with the greatest comfort to the patient. He believed that early movement in these injuries did not cut much figure in the ultimate result, as a large amount of the plastic material thrown out in the early stages was subsequently absorbed. He therefore believed in trusting to movement later, and, if necessary, under an anesthetic.

DR. H. L. NICHOLS believed there was nothing gained by early motion.

Hysterical Convulsions Simulating Eclampsia.—DR. F. B. SUTLIFF said: I would like to report a case that at first gave me some little trouble. During the past week Mrs. McC—— was delivered of her first child, with nothing remarkable regarding the labor. She seemed to be doing well for the first two days after delivery, having had no fever nor any symptom pointing toward complication or trouble. On the afternoon of the third day I was urgently summoned to see her, as she was "dying." I found her in a convulsion and wholly unconscious. I was told that the condition developed rapidly, without warning, and that she had never had such an attack before; her sister, who was present, having always known about her health. It did not look to me like a convulsion from uremia, nor was there any suppression of urine, no swelling of the feet nor any symptom to indicate such a cause. She did not snore, there was no twitching of the eyelids; she muttered, and when sharply questioned or spoken to, she would make some half-way effort to reply. She became a little better after a few hours, only to have another attack, and others from time to time for two days. At no time during the two days was she wholly conscious. On the third day she was rational, bade me good morning as I entered her room, but said that she was blind. I asked her how she knew that it was I, and she replied that she knew by my voice. She admitted knowing that it was daylight, but could not count my fingers held before her eyes. The next morning sight had returned, and her complete recovery was uneventful. She remains well save for a badly burned foot, caused by a hot stove-lid applied during the first convulsion. I look upon the case as one of hysteria, but, occurring as it did soon after confinement, it was well calculated to deceive. She had had retention of urine for a day or so, and a sample, drawn and tested, showed no trace of albumin.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, Tuesday, September 11, 1894.

The President, W. WATT KERR, M.D., in the Chair.

New Member.—A. NELSON BEACH, M.D., was duly elected a member of the Society.

Aphasia, with Amnesia, Paraphasia and Agraphia.—DR. W. WATT KERR presented a patient 51 years of age, who came under his observation four and a half months ago. He was taken suddenly with ataxic aphasia, amnesia, paraphasia, and agraphia. He complained at first of severe pain in the head, which was confined to no special region. At present he shows great improvement, the headache and amnesia have disappeared, the aphasia is nearly gone; there has been no paraphasia in the past six weeks; agraphia is slight, and the tongue, on protrusion, points toward the right. He repeats "round about the rugged rocks the ragged rascals ran" quite well. The interesting feature is the extreme interference with speech, and the very slight paralysis. The trouble has most likely been due to embolism in the primary branches of the middle cerebral artery. There is no specific history, and the patient does not drink or smoke. He has, however, hypertrophy and dilatation of the heart, with slight mitral regurgitation. The treatment pursued was, first, iodide of potassium, and, later, strychnine.

DR. C. G. KUHLMAN thought that the trouble was not due to embolus, because the blood vessels in that region were large, and it ought to have given rise to graver and more permanent symptoms.

Severe Hemorrhage following Tonsillotomy.—DR. C. G. KENYON reported the following case: About two weeks ago he removed a tonsil from a lady with the usual curved scissors. The operation was followed by rather profuse hemorrhage, which, however, ceased in a few minutes without any styptic measures. In the evening the patient returned, accompanied by her husband. Hemorrhage had come on after leaving the office, and was very profuse, she being quite exsanguinated. On arriving he found a fellow practitioner in his office endeavoring to arrest the bleeding with ice. Digital compression was then tried without satisfactory results. A hemorrhoidal forceps was next applied about the stump of the tonsil, and a ligature placed above it. This was a very difficult proceeding, as the patient was beginning to suffer from syncope. After two days the ligature slipped off during the evening when the patient was at the theater. Late that night she reappeared at his office in a great state of excitement, and spitting blood quite freely. He then passed a curved needle, armed with a ligature, through the tonsil, or rather what was left of it, from below upwards, and for a time this seemed to be effective. A few hour later he was called to her house. There was not much hemorrhage, but the patient and her husband were alarmed. The speaker again resorted to the curved needle, passing the ligature from behind forward, including the anterior pillar of the pharynx, effectually staunching any appearance of blood, and there has been no trouble since. This last ligature still remains, the first one having come away two days ago. He anticipated no further trouble. The tonsil, or rather the remnant remaining, has completely atrophied. There was nothing amiss in the operation, a complete excision had apparently not been done as otherwise there would have been no stump to secure. He was quite satisfied that the patient was a "bleeder," as she had since informed him that she once very nearly "bled to death" (using her own expression), after an operation. He would not undertake to remove a tonsil from this patient again, even if she desired the operation; and in the light of this experience he would always undertake the operation with some little trepidation in future. He did not believe that any one could have anticipated such a contingency, as there was nothing in the appearance of the parts, or of the patient, to render such an outcome at all probable. He believed that the plan adopted in this case was a good one, though it would undoubtedly be very difficult to perform on a child.

Rupture of an Ovarian Cyst during Labor, Causing Death in Two Days. DR. KENYON also reported a case of parturition in a strong, healthy primipara. The first stage was prolonged, but delivery was accomplished with no unusual circumstances. Shortly afterwards a condition of collapse supervened, which it seemed impossible to account for. There was no rise of temperature. Notwithstanding the uterus was washed out, supporting treatment was adopted, but the patient died within two days. Regarding the case as one of some obscure trouble he insisted upon an autopsy, which was granted. This revealed a ruptured ovarian cyst, which accounted for the fatality.

DR. C. G. KUHLMAN said he never operated in acutely inflamed tonsils. He believed that a strong solution of cupric sulphate never failed to arrest a hemorrhage from this source. The second case reported by Dr. Kenyon was certainly a rare one. We never have pregnancy if both ovaries are degenerated. He did not believe that cysts were an obstruction in such cases.

DR. G. W. DAVIS said Dr. Kenyon's method of checking hemorrhage in the case of tonsillotomy seemed new, and the *modus operandi* was certainly important.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, August 18, 1894.

The President, JOHN F. MORSE, M.D., in the Chair.

DR. N. ROSENCRANZ read a paper on "One of the Causes of Frequent Micturition in the Female," [published at p. 642] and exhibited the specimen, a small fibroid.

DR. DUDLEY TAIT: I like to see a limited subject chosen, but in this instance the plan gives rise to errors. The fact that this patient had urinated too frequently for several years, and after the removal of this *very* small fibroid, was restored to health, does not tend to show that the recovery was the result of the removal of the tumor. We all know that astonishing results often occur after abdominal operations. In fibroids, we meet with pathological changes in the uterus that give us frequent micturition—also from retroverted uteri, hematocele, and all masses that cause pressure symptoms from their bulk and weight. Now, in this case, there certainly were *no* pressure symptoms, the fibroid being so very small. If these symptoms were due to weight or adhesions we would certainly have as much trouble after as before the operation, as more adhesions would be formed and even cicatrices.

DR. E. CALDERON: Perhaps in this case there was some hysteria, and the result of the operation was due to the mental effect of the treatment. I should advise that Dr. Rosencranz wait awhile and see if it is entirely cured.

DR. D. W. MONTGOMERY: As Dr. Tait has said, this fibroid is very small to have caused such trouble by pressure. I believe it would be wise to keep the case under observation for a time, before stating positively that a cure has been effected. The operation *per se* might have caused a cessation. It is only four weeks since the operation—hardly long enough for one to be sure that a thorough cure has taken place.

Dr. Rosencranz: Regarding the hysteria theory, this patient was under Weir Mitchell and took his rest cure for six weeks without any benefit. This small growth was on the anterior surface of the bladder—about the center of the base. One could understand small growths near the neck setting up such symptoms. They were caused by irritation, not by pressure.

The President: This case is interesting, and the ultimate results will be watched with much interest.

The President: I should like to bring before the Academy for discussion the subject of the thyroid gland, and its surgical treatment. This gland is now occupying the attention of the surgeons. I have now a case of simple parenchymatous inflammation of the thyroid; the patient desires to have the gland removed. I understand there are surgeons here who remove it entirely, but I believe this practice to be antiquated.

Dr. D. W. Montgomery: Myxedema generally results after removal of the thyroid, and is combated by the administration of desiccated thyroid or the sheeps' thyroid given when fresh.

Dr. Dudley Tait had lately had a case where the walls were thickened, and in the center was found a small cyst; this case terminated happily. In Switzerland, operations on goitre are frequent—and he believed total extirpation was not advocated.

Dr. R. W. Baum: I have seen many operations in Frieburg by Prof. Maass. If the tumor were not too large, total extirpation was done. Death occurred in some instances, where the mass was large, from the wearing and subsequent breaking of the tracheal rings. In small goitres, I have seen good results from iodine, internally and externally.

Dr. Tait: I have not seen good results from iodine; I have seen it used in pregnant women, and at the same time tonics were given, with no benefit; nor have I observed any benefit from parenchymatous injections.

Dr. E. Calderon: I have treated two cases by potassium iodide internally, and an ointment of the proto-iodide of mercury, externally. The treatment was quite painful; in three weeks an eczema appeared. The ointment was suspended for three weeks and was then resumed. The goitres were not large, and good results followed, which I do not attribute alone to the external treatment. In Switzerland, a part of the gland is left to avoid myxedema—which will certainly appear after total extirpation; I believe it best to allow the isthumus to remain.

The President: I was always under the impression that in extirpating the thyroid, it was necessary to leave a portion, as myxedema always follows total removal, and was quite surprised to learn that surgeons here advocated the total removal of the gland.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, September 3, 1894.

The President, F. Z. Bazan, M.D., in the Chair.

Dr. A. E. Brune read a paper entitled "Something about the Nature of Diabetes Mellitus." [Published at p. 648.]

Dr. Henry Gibbons urged the importance of mental rest in the treatment of diabetes.

Dr. L. C. Lane said while he was a student at Göttingen he worked a long time in the physiological laboratory. One day the liver of a patient who had just died of hydrophobia was given him for examination. He extracted the glycogen and found the amount remarkably large. He remembered to have seen the experiments of Claude Bernard where by the needle prick he produced a glycosuria. In regard to treatment, he had tried in a few cases tincture of iodine, as recommended by Bouchard, of Paris, but without beneficial effect. Cantani advised the use of lactic acid. The speaker had used it with very great success in reducing the amount of sugar excreted, so that in some cases the specific gravity fell from 1040 to almost normal. The patient is fed on meats, and is given from half a drachm to a drachm of pure lactic acid diluted with some inert substance such as glycerin. He had seen it act pronouncedly within 24 hours. Certain mineral waters are recommended. He had found Bethesda water to have a decided effect. A patient of his, a chemist, who suffered from diabetes, gave a good account of the effect of the water at the springs. He said that many patients there rapidly became better. Only of late some writer claims that he made his patients eat sugars and starches, not only with impunity but with benefit.

Dr. I. Rivas said in some cases it was impossible to restrict the diet to albuminoids alone. He had, two years ago, a case in an old person who was greatly emaciated, in which he allowed anything to be eaten. No evil apparently resulted.

Dr. Stanley Stillman said he had seen two cases in which any mental strain brought on an increased excretion of sugar. Dr. Brune laid no stress on the use of drugs. He believed it was the duty of the physician to administer those few drugs which are of benefit, but chiefly because that is one of the most effective means of securing mental rest. To send a man to the springs, or to tell him not to worry, is easy to do, but the man will not stop worrying. When he is taking medicine, even if it does him no good, it makes him think something is being done for him, and contributes to his peace of mind.

Dr. Basil Norris told of a case where a boy became deranged—demented to a slight degree. His father was greatly worried and began to be troubled with diabetes. Another case was always pleased with a new remedy. For a while his favorite drug was arsenic.

Dr. R. H. Plummer said this question of diabetes reminded him of a statement made by a medical man a few years ago, when he was Secretary of the State Board of Examiners. It so happened that the diploma this gentleman presented was without date, and hence not valid in the eyes of the law. The doctor said that he had never looked at it since it was given him on the platform. He knew that he was not much of a doctor, but now he doubted whether he was a doctor at all. So it is with this subject of diabetes. It is doubtful whether any of us are doctors at all. Dr. Plummer referred to a number of cases he had attended. In one the specific gravity of the urine dropped in three days from 1040 to 1018, when Bethesda water was given. The benefit was, however, but temporary. In many patients no benefit whatever is derived from this water. He had tried lactic acid in two cases without effect. Large doses of ergotin had a little effect in some cases, none in most cases. He had, at present, a patient excreting from 6 to 12 pints of water in 12 hours, with a specific gravity of 1038 and 1040. He had given ergotin, opium, lactic acid, electricity, Bethesda water, and many other things, and the urine was never brought below 5 pints in 12 hours, and the specific gravity was never below 1036. He had seriously thought of removing all restrictions as to diet as a last resort.

Dr. Lane said that coma should not be forgotten. It is well to prepare the patient and his friends for such a contingency.

Dr. C. N. Ellinwood had used piperazin, which, while the patient takes it; reduces the amount of the urine and the specific gravity.

Dr. E. W. Thomas had noticed in a recent article on the subject that levulose was suggested to be used in place of starchy foods. He had seen arsenic recommended in the form of arseniate of soda.

Dr. K. Pischl said the oculist is often the first to make the diagnosis in albuminuria, and sometimes in diabetes also. Cataract occurs frequently in diabetics. This is due to the disturbed condition of the ciliary vessels. Such cataracts, if not of too long standing and too extensive, may clear up again. Occasionally retinal inflammations are observed, hemorrhages, fatty degenerations, neuritis, and paralysis of accommodation and of the external muscles.

Meckel's Diverticulum.—**Dr. Emmet Rixford** exhibited an example of Meckel's diverticulum found at a *post-mortem* examination. He also demonstrated certain lesions of the kidney which are characteristic of diabetes.

CALIFORNIA NORTHERN DISTRICT MEDICAL SOCIETY.

Fourth Annual Meeting, held in Marysville Tuesday, October 9, 1894.

MORNING SESSION.

The fourth annual meeting of the California Northern District Medical Society was held at Masonic Hall, Marysville, Tuesday, October 9, 1894. In the absence of the President, W. A. BRIGGS of Sacramento, the Society was called to order by the First Vice-President, R. F. ROONEY of Auburn.

Addresses of Welcome.—The Honorable W. T. ELLIS, Jr., Mayor of the city said: Mr. President and members of the Northern District Society: In behalf of the citizens of Marysville, I extend to each and every one of you a hearty welcome; and the freedom of the city is at your disposal for as long as you may desire to remain with us. On account of the excellent health enjoyed by our people we find, as a usual thing, that our resident physicians are more ornamental than they are useful; but on this occasion I am quite satisfied they will reverse that usual order of things, and make themselves useful in the way of thoroughly entertaining their guests, so that when you leave us you will carry with you an impression that Marysville has sustained her reputation for hospitality. We are honored by your presence, and I trust that your session will be a most agreeable and satisfactory one.

DR. DAVID POWELL, of Marysville, the Chairman of the Committee of Arrangements, said: There is nothing that affords greater pleasure than the privilege of greeting a welcome guest, and in behalf of the members of the Medical Society of Yuba and Sutter Counties, and as Chairman of your Committee of Arrangements, the very agreeable duty devolves upon me of expressing to you the unfeigned pleasure which we experience from your presence here this morning. This large attendance is not only gratifying to us at whose invitation you have assembled here, but nothing could better evince your loyalty to the profession of medicine and your genuine interest in medical progress. Neither the fatigue of travel, the sacrifice of valuable time, nor the deprivation of the accustomed comforts of home, has deterred you from lending your influence to, and by your presence insuring, the success of the fourth annual meeting of this Society. But we trust that the consideration of the very excellent program before you will prove sufficiently interesting and instructive to convince all that you have been fully compensated for all the trouble, and inconvenience, and sacrifices, to which your attendance here this morning may have subjected you. Of late years there has been a very marked increase of interest manifested in medical organizations. Physicians are learning to appreciate more and more the benefits, the importance and the value of medical societies: instituted as they are, for mutual improvement, mutual protection, and the cultivation and advancement, of medical science. Indeed, the phenomenal progress which has marked the history of the science of medicine, in all its departments, during the past decade of years, may be largely attributed to the impetus which the study of medicine has received from systematic and thoughtful work done in medical societies. And yet, while physicians are devoting their time and best energies to achieve greater success in their profession, and exerting every faculty to acquire still greater skill in the practice of the art, their efforts are far from being generally appreciated. The injustice of public sentiment and the ingratitude of the average individual are never more apparent than when measures for the preservation of the public health are sought to be inaugurated by the medical profession. What other profession or calling exists whose members are daily advocating measures, the adoption of which would curtail their business and lessen their income? I will venture to say that, aside from the medical profession, you will look in vain over the whole field of professional and business pursuits to find a single example. Even the honorable and learned profession of the law, for which we all have the greatest respect, does not always manifest the public spiritedness, the unselfish interest in the welfare of others, that distinguishes the profession of medicine. An instance occurs to me—and I speak of this not disparagingly of the profession as a profession, but to show you an instance of individual bias in this matter: Not very long since a prominent member of the bar in our own legislature opposed the enactment of a law in which physicians were interested, because, as he stated, its operation would have a tendency to lessen litigation. This same man is now prominent in the councils of the nation, and a distinguished disciple of Blackstone. Let us hope, for the credit of the great profession which he disgraced, that his utterances were but the selfish, sordid sentiment of the individual's own moral obtundity. Physicians, on the other hand, are continually striving to disseminate among the public a knowledge of sanitary laws, and are using every means known to science to preserve health, and check the spread of communicable diseases. There is scarcely a hamlet in the State that has not a Board of Health, composed largely of physicians, who are earnestly engaged in promoting sanitary measures for the protection and well-being of the community in which they reside. So that, with the one great object in view, the physical welfare of our fellow-beings, we devote time and money in attending these medical societies, and medical associations, in attending sanitary conventions, State and local Boards of Health, without hope of reward or expectation of any compensation save the satisfaction of faithfully performing the high, and sacred, and self-imposed duties devolving upon us as earnest devotees of the healing art. Four years ago the California Northern District Medical Society was organized with less than a score of members, and representing but three counties: Butte, Yuba and Sutter. To-day we have a membership of over half a hundred, with representatives from nearly every county north of San Joaquin and Solano; and, as there are upwards of three hundred physicians in the district, many of whom have already expressed a desire to unite with us, we may reasonably expect in the near future still greater accessions to our numbers. It may not, therefore, be considered merely a fanciful, chimerical dream, to predict that the time will soon come when this Society will be second only to the State organization, not only in usefulness but in numerical strength. The program which is now before you has been carefully arranged, and will, we hope, meet with your approval. As you observe, there will be a morning, afternoon, and an evening session. The committee has endeavored to allow sufficient time for the reading of papers during the forenoon and afternoon sessions, the evening session to be devoted to the transaction of unfinished business, the election of officers for the ensuing year, the selection of the next place of meeting, etc.; at the close of which you are all cordially invited to participate with us at a banquet at the New Western Hotel. We extend to you all a hearty, sincere, fraternal greeting. We welcome your coming, and when the day's work is finished and the time comes for you to take your departure, we hope that you will carry with you agreeable memories of this occasion, and pleasant reminiscences of your brief sojourn with us.

Oliver Wendell Holmes.—T. W. HUNTINGTON, of Sacramento, moved that when the Society adjourn at noon, it do so in respect to Oliver Wendell Holmes, the poet, patriot and physician. The President, in putting the motion, which was carried unanimously, said the name of Dr. Holmes was "dear to all our hearts."

Chronic Interstitial Nephritis.—J. E. RODLEY, of Chico, read a paper upon this subject. He wished particularly to direct attention to the clinical features of the disease, omitting reference in detail to the morbid anatomy. His experience had led him to believe that many persons suffering from this form of Bright's disease are treated for some of the many complications arising during its progress, without suspicion of the real nature of the complaint. This was due rather to incompleteness of examination than to want of knowledge on the part of the practitioner. He was also satisfied that most of the subjects of this disease had been affected for some time before their condition was understood; the symptoms in the earlier stages being so trifling as to cause no anxiety, and to readily escape a superficial examination. The speaker illustrated his position by reporting two cases: The first, that of a patient who had, for some time, been treated for chronic pneumonia, which absolutely resisted medication. On falling into his hands, examination showed dulness on percussion over the base of both lungs and fine crepitant rales. There was cough, with white frothy expectoration, and moderate dyspnea. The heart was found to be enlarged, and examination of the urine showed the presence of albumin. Inquiry into the history of the case revealed the fact that, though active both mentally and physically, the patient had for some time suffered from digestive derangements and shortness of breath on exertion. The second case had consulted him for a cough, with white, frothy expectoration, which his former physician had informed him was due to bronchitis. Physical examination showed dulness over both lungs, posteriorly, and cardiac hypertrophy, and albumin in the urine. This patient, who had always considered himself to be in good health, was so distressed at the diagnosis and prognosis that he went elsewhere and was again treated for bronchitis, and subsequently for asthma and stomach trouble, but finally returned with a moderate amount of dropsy and greatly increased dyspnea. It would seem that in some cases, where the changes in the kidney have been far advanced, a sudden exposure to cold, by arresting the function of the skin, throws additional work on the kidney, thereby developing the graver disease. The most constant feature in contracted kidney is the absence of visible dropsy, at least in the early stages. He believed that many of these cases were due to long and persistent dyspepsia. A lesson to be learned from this theory was that attention should be given to all cases of persistent dyspepsia. In diagnosis, the frequent use of the microscope was a safeguard against error and an early warning in incipient mischief.

Dr. G. W. **Stratton**, of Marysville, said this was one of the most important forms of Bright's disease, because it makes its appearance so slowly that it is rarely discovered until the disease has become seated. As Dr. Rodley says, it is often overlooked by the patient as well as by the physician.

Dr. W. E. Bates, of Davisville: I would like to ask Dr. Rodley if he has used nitro-glycerin in these cases; and, if so, with what result? He touched but little upon the treatment; in fact, I did not hear that he offered anything upon that point at all. I have used nitro-glycerin in these cases, and I have had excellent results from it.

Dr. Rodley, of Chico: In all cases of chronic interstitial nephritis that have come under my care, my results have been better where I could get the skin to act. The first thing the anatomical conditions of the disease would indicate is that there is very little we can do to relieve the kidney. The mischief has already been done. The kidneys cannot secrete the urine, and not near the amount necessary, or that a healthy kidney would carry away, can be removed. The contraction of the tissues involves the whole body of the kidney, but the cortical substance more especially, so that both kidneys are not doing one quarter the work they ought. Edema of the lungs follows, that being the point of least resistance and the lung tissue being weaker, and extravasation of serum into the air cells, with consequent dyspnea, occurs after the disease is far advanced. Relief in a condition of that kind can only be afforded, in my belief, by getting the skin to act vigorously, thereby removing the water from the blood, which relieves the kidneys from the tension under which they are suffering. After the edema has been removed to a certain extent, it seems to relieve the tension, and the patient gets along very nicely for a time, being often able to attend to business for quite a while, especially in warm weather. My experience with most of these cases has been about the same, where the kidneys are in that condition, and I do not believe there is anything in medication that will remove it after it is far advanced. As to the action of nitro-glycerin, I have frequently used it, and have never seen any direct action on the kidneys. It does have a very good effect on the heart's action in some cases. I have also tried cactus pellets, but they have not given me the satisfaction that nitro-glycerin has.

Dr. Thos. Ross, of Sacramento: I was much pleased with that part of the paper which called the attention of the profession to the necessity of an early diagnosis in this disease. By making an early diagnosis, we can protract the patient's life almost indefinitely. It is a disease, as we all know, that comes on stealthily; where the patient is in apparent health and attending to his daily business for a long while, perhaps, after it has commenced its ravages on the kidneys. I remember a case, some five or six years ago, seen in consultation with Dr. Macfarlane, of Woodland, where we used pilocarpin, by injection, with very good effect. Indeed, I believe but for its use the patient would not have survived many hours. In the treatment of the disease more can be done by regulating the diet and guarding against cold than by any medication. Of course, complications, such as dyspeptic symptoms and edema of the lungs, require attention. Whenever a patient between the ages of 40 and 60 complains of some difficulty in breathing, and on a physical examination an enlarged heart and an atheromatous condition of the radial artery is found, our attention should be immediately called to the kidneys, and we might then make a proper diagnosis, which otherwise we would not do.

Dr. W. E. Briggs, of Sacramento: I have frequently seen cases of eye trouble arising from chronic interstitial nephritis, which had escaped the observation of the physician. More often, probably, the patient did not consider himself particularly ill, being able to attend to business, until his eyes began to fail, and on examining them I have found albuminous or white patches, and occasional imperfections in the retina. Occasionally we find that the physician has overlooked the patient's condition in that respect until these changes have become established. The slow and insidious development of the symptoms in these cases is the reason that the pathological condition is not sooner recognized. It is very important in all cases of chronic trouble, where the patient does not recover promptly under treatment, to examine the urine, and you will then discover the trouble very much sooner.

Dr. O. Stansbury, of Chico: There is one question I would like to ask Dr. Rodley, for my own information and for that of others: Suppose we are called to a case where cardiac asthma exists; examination of the urine reveals albumin; would we be justified in considering that a case of Bright's disease of the kidneys, primarily or secondarily, from the heart trouble? I would be inclined myself to regard this as primarily heart trouble, the other troubles coming on as secondary conditions.

Dr. Rodley: The only true way to arrive at a diagnosis of interstitial nephritis, or in fact of any form of Bright's disease, is by the microscope. There are very many acute diseases, even pneumonia itself, which is very common among us, where at times on examination of the urine we will find albumin. But in those cases you never find any epithelial cells or any granular or hyaline casts. You may have a heart affection which is caused not by any kidney trouble, but by trouble with the heart itself, such as enlargement of either side or aneurism in any part. Still, in the absence of epithelial cells and granular or hyaline casts in the urine, I should not feel disposed to make a diagnosis of Bright's disease of the kidneys.

Dr. T. W. Huntington, of Sacramento: I did not intend to discuss this subject, it not being one with which I am especially familiar. At the same time it seems to me there is an opportunity for error to get abroad from something that has been said in regard to the relation between heart troubles and the consequent renal affections. I believe it is generally understood and accepted now, that an organic lesion causing unnatural disturbance of the circulation may result in true chronic interstitial nephritis. By that, I mean: carry with it all the evidences of chronic interstitial nephritis. In all valvular trouble of the heart we may look out very sharply for disturbance in the renal organs, which will be as serious and more certainly fatal than the original trouble in the heart. For that reason, wherever we find in early life an affection of the heart which is almost certain to be permanent, as valvular trouble, we ought to caution against exposure and against excesses of any sort, on account of the very probable serious involvement of the kidneys which may ensue therefrom.

Dr. B. F. Gill of Dunsmuir: In my opinion the indiscriminate use of drugs, especially for the treatment of gonorrhea under the old method, and the common forms of syphilitic affections, is largely responsible for many cases of chronic interstitial nephritis. In chronic inflammation of the kidneys resulting from dyspepsia or indigestion, I fully agree with Dr. Rodley in giving great stress to the treatment of the skin. It is an established fact that every catarrhal affection of the mucous surface is particularly aggravated by an inactive condition of the skin. I find in my experience that it is not a good plan to coddle the patient; but the skin should be treated with stimulating baths and washes, and sometimes with oil, that he may become more hardy.

Dr. Nelson Watts, of Chico: In the treatment of true Bright's disease, I have had very excellent effects from the use of muriated tincture of iron and acetic acid. I remember one patient who, a few years before, had had a double dose of typhoid fever and nearly died from it, and who came to me with every symptom of true Bright's disease. His urine was loaded with albumin; he had cyanosis, and that doughy, bluish appearance that we find in that disease. I treated him with muriated tincture of iron and acetic acid, and he recovered. In about two years he returned in a similar condition, and I treated him in the same way, and he again recovered. That was years since, and he is still alive and well, a sound and hearty man. Now I wish to say a word about another form of the disease which I call malarial Bright's disease, of which in forty years' practice in a malarious section I have had three or four cases. In each there was every indication of Bright's disease; but I discovered it was simply the effects of malaria. In the cases referred to I used the anti-malarial treatment, which you all understand, and the patients were cured.

DR. ROSS of Sacramento: I can bear testimony to the beneficial effects of muriated tincture of iron in the treatment of chronic Bright's disease, in a case where the urine was apparently three-fourths albumin in volume, where there were hyaline casts and all the microscopical evidences of the disease present. I gave it sometimes in teaspoonful, but generally in half teaspoonful, doses, in milk, three or four times a day, and the effect was something remarkable. Dr. Macfarlane is well acquainted with the case.

DR. W. W. MACFARLANE, of Woodland: I remember it very well. It was rather a peculiar case. I have since seen the lady, who lives next door to me, every day. She had a miscarriage—an abortion in fact—was very badly managed and was in a very bad condition. Her ankles were almost as large as her thighs, there being hardly any difference in size from her thighs to her feet, and the tissues were full of water. I know that Dr. Ross gave her tincture of iron until she could not take it any longer, when he would stop its administration and wait a week or two and then give it to her again. She now seems to be in perfect health.

DR. RODLEY, of Chico: I have used the muriated tincture of iron, not only because of its styptic qualities but to increase the hemoglobin and strengthen the blood. We all know that in Bright's disease there is an increase of water in the blood—that it is not carried away as it should be, and consequently the blood vessels become distended, and, being distended, the water retained in the blood leaks through into the cavities of the body. I can understand how tincture of iron, in that condition, would be very beneficial. But we must first get the skin to act, so that we may get rid of that excess of water which has accumulated in the cavities. I never saw a case of any form of Bright's disease, or, in fact, of any active congestion of the kidneys, where there was not more or less effusion in some portion of the body. If that has continued any length of time it is absolutely necessary that the circulation should get relief in some way; and it will relieve itself by throwing out the water in the blood through some portion of the body or of the skin. A profuse perspiration will relieve such condition. Dr. Ross spoke of administering pilocarpin with very good effect. I have seen that done on several occasions, but I must say I am afraid of it. If you have a heart which is fluttering and faltering, and a high degree of effusion, and give pilocarpin, with the rapid effect it sometimes has, it is liable to do injury. I have given it myself in one or two cases, but it never seemed to act as well as jaborandi alone. In such cases I generally put the patient on jaborandi, and give it in small doses; and very often I will give about half a teaspoonful of the infusion every hour until it produces a diaphoretic effect. It seems to do better; it does with me. But pilocarpin, which I have used, as I say, in some cases, acts so quickly and its action stops so quickly that you do not derive from it that steady relief obtainable from jaborandi. I give the jaborandi, in about half teaspoonful doses every two or three hours, until there is quite a profuse diaphoresis which always continues for a long time. I have had to keep it up for two or three days, and the patient would seem to get relief and to get better with every dose he took. The muriated tincture of iron, in conjunction with jaborandi, I should think would have a very beneficial effect, where there was any effusion, or where the blood vessels were distended. The iron would contract the blood vessels, rid the system of the excess of water in the blood and build up the blood.

AFTERNOON SESSION.

The Importance of the Early Recognition of Strabismus and of the Prevention of Ophthalmia Neonatorum.—W. E. BRIGGS, of Sacramento, said: Preventive medicine is beginning to receive the attention that its importance demands from the general practitioner, but the specialist occasionally sees very sad results from neglect of well-recognized prophylactic measures. Were Credé's method of dropping a 2-per-cent. solution of nitrate of silver into the eyes of the new-born and a proper cleansing of the eyes carried out, there would be a very marked decrease in the number of inmates of our blind asylums. Were prompt measures taken to relieve children who suffer from obstructed nasal breathing, we would see fewer deaf grown people. The point he wished particularly to emphasize in his paper was the importance of early examination of all children who have a tendency to convergent strabismus. This can be made plain by giving, in a concise manner, the conditions producing strabismus. A large proportion, probably three-fourths, of the cases of convergent strabismus are caused by far-sightedness, which can be corrected. If the hypermetropia be corrected by glasses before the deviation has long existed, the tendency to converge is likely to be relieved and a worse fate obviated. If the squint has become permanent and not alternating, the deviating eye is sure to be nearly blind. Even if the eye be restored to proper position by an operation, it is very problematical whether the vision in the deviating eye is restored and binocular vision regained.

Dr. C. H. Gibbons, of Arbuckle: It is not in the range of the general practitioner to take the place of the specialist, but we all should feel the great responsibility resting upon us in these cases of incipient strabismus. I am satisfied I have myself accomplished much good in preventing such cases from developing; for I consider it as imperative a duty to prevent disease as to attempt to cure it after it has become established. There can be no question of the importance of recognizing the early symptoms in the cases referred to, and thereby obviating future serious results.

Dr. David Powell, of Marysville: This paper is of particular interest to the general practitioner, for the reason that on him rests the responsibility in a great many cases, if not in a majority of cases, where children are troubled with eye diseases. I cannot recall now who has made the latest investigation of the matter, but I remember reading, some time ago, a report by Dr. West, I think, of New York, who had examined the eyes of a great many children in the asylums for the blind, and he concluded, after a careful research into their history, that in the case of some 60 or 65 per cent. of those who were totally blind, the affliction was due to ophthalmia neonatorum. So we can all readily see what responsibility rests upon every practitioner who attends these little ones at their birth. It has been my custom for a number of years to personally attend to the washing of the child's eyes, and not leave it entirely to the nurse. I am in the habit of directing the nurse to first wash the child's face, and not to use for that purpose water that has been previously employed in washing the body, but clean water; and then to cleanse the eyes thoroughly. If there is any suspicion of inflammation, or if there is found to be a purulent discharge from the vagina, I use additional precautions, instilling into the eyes, after washing the lids with warm water, a drop of a 2-per-cent. solution of nitrate of silver. That, I think, has been recommended by many of the leading obstetricians and oculists, to prevent the development of the ophthalmia. By taking these precautions, we can often prevent the greatest misfortune that can afflict a human being—total blindness. Of course, in ordinary private practice, it is not necessary always to use such strong remedies, but I always superintend the cleansing of the child's face and eyes, in every instance. There are a great many conditions found after birth, injurious to the child, that should be attended to, as the doctor suggests in his paper, and the fact that the attention of the Society has been called to these matters is likely to prove of great benefit, because we are apt to overlook these little things, when, if attended to promptly, and at the time, much suffering and annoyance in the future might be avoided.

Dr. J. H. Parkinson, of Sacramento: The point to which Dr. Powell has just spoken is one that I was about to raise myself. The care of the eyes of the new-born is certainly a most important feature in the management of any labor case, and one which I think receives too scant attention in many instances. Like Dr. Powell, for several years I have personally attended to that matter. I have washed the eyes of the child with clean water. But in the last two years, in spite of what I considered careful attention, I have had three cases of ophthalmia neonatorum. I then decided, with the advice of the author of the the paper just read, that it was better to use a germicidal solution, and for some time I employed bichloride of mercury, 1:4 or 5,000. Not many months ago, I came across a case which rather upset my theory in that regard, and which has rather upset me since. The child was born about 11 o'clock in the day. The eyes were first carefully washed, and then bathed with a mercurial solution. When I saw the child on the following morning, there was considerable edema of both lids and a profuse purulent discharge. The father told me that on the previous evening, not more than 10 hours after delivery, there had been a similarly violent purulent discharge. We know that many authorities among oculists believe that all cases of ophthalmia neonatorum following labor are gonorrheal in character. That view, however, I am not prepared to accept. In this particular instance I inquired faithfully, but failed to elicit anything which would attach suspicion to either parent of either recent or former discharges. The case was certainly one of very ugly inflammation, and so severe in character, and coming on so rapidly, that it was difficult to decide what was the predisposing cause. Dr. Briggs saw the case within an hour after the diagnosis was made, and, while severe for 48 hours, the trouble eventually subsided, and recovered under his treatment. I raised the point myself as to whether or not the mercurial solution had anything to do with it, which he did not believe. Since then I have been using the nitrate of silver solution which Dr. Powell mentions, and have had better success with it. I believe, however, that it is necessary, in using that solution, to wash out the eye afterward; not merely to put a drop or two in each eye and let it remain there, but after it has remained half a minute or so, to wash out the eye with boiled or clean water. If this be done, it will avoid all irritation, for a solution of that strength, I think, is likely to be irritating in character, while antiseptic.

DR. W. E. BRIGGS, of Sacramento: The attention of the medical profession has been called to the subject of ophthalmia in children as very common in the last few years, and facts have been carefully collated. From the history of the cases in the blind asylums we find, as Dr. Powell has said, that a very large percentage of the blindness is due to ophthalmia neonatorum. That fact should certainly put us on our guard and make it incumbent on physicians attending labor cases to pay very strict attention to the eyes of the new born. The eyes should be washed out with clean water before anything else is done to the child, and either a solution of bichloride of mercury (1:5000) or a solution of nitrate of silver should be dropped into the eyes and the eyes again washed with clean water. I think this is the experience of physicians in the large hospitals, and every physician should pay strict attention to it. Physicians in general practice see so few of these cases that they do not regard them with the same gravity as does the specialist who sees so many. I remember last summer two infants being brought to my office within a week with the sight of both eyes totally destroyed from this disease. To avoid this it is not too much, it seems to me, to ask every physician to take these precautions; and if they will, I believe they will be usually able to prevent the occurrence of severe cases. Of course if such do appear they need urgent and thorough treatment. Drop in nitrate of silver, and if nitrate of silver is not sufficient the eyes must be thoroughly cleansed with either a bichloride or boracic acid solution every half hour or hour while the purulent condition remains. The point that I have specially tried to bring out in my short paper is the importance of the correction of the first tendency to strabismus. Upon the first symptoms of deviation of the eye in children the eyes should be examined for any anomalous condition; and if this is done a very large percentage of cases of strabimus that come up for operation will be prevented. The cylinder will relieve the tendency to contraction of the internal recti-muscles, the eye be freed from the strain, and future trouble or blindness of one eye be avoided, as well as the necessity of a future operation, which is of considerable gravity as regards the vision of the eye.

DR. POWELL, of Marysville: I would like to ask Dr. Briggs whether in ordinary cases occurring in private practice, where there is no suspicion of syphilitic trouble and apparently no purulent discharge, he would always take the precaution he mentions, particularly the use of nitrate of silver.

DR. W. E. BRIGGS, of Sacramento: I believe it is better to take these precautions. Personally I believe a great many cases of ophthalmia neonatorum are not specific. I believe there are a great many other causes for it than gonorrhea. For that reason I think the eyes ought to be cleansed and all irritating secretions, if possible, prevented from getting into them. If one is sure there is no gonorrheal trouble and never has been any inflammation, I do not think it so essential. But I do not think we can be too sure. Often there are undetected gonorrheal secretions where you cannot get any history of gonorrheal trouble. I believe even if there is not a specific history it is advisable to take the precautions named, because they will not do any harm and their employment will frequently avoid serious trouble.

DR. PARKINSON, of Sacramento: In one of the cases which I have mentioned

Dr. Briggs did not succeed in curing it in less than three weeks. Here there was absolutely no suspicion of gonorrheal trouble in the family, and the mother, previous to her labor, had not even been troubled much with leucorrhea. In that case I washed the child's eyes out myself with bichloride of mercury solution, but, in spite of all precautions, the child had ophthalmia, and the attack was quite severe on one side.

The Climate of the Sierra Nevada Foothills and Its Influence on the Diseases of the Respiratory Organs.—R. F. ROONEY, of Auburn, read a paper upon this subject. It was accompanied by a number of tables illustrating the monthly and seasonal averages extending over a number of years, the data presented relating to Auburn. The speaker said the topic upon which he had been requested to write was not a congenial one, as any favorable comments that he might make would naturally be regarded with some suspicion. At the outset, he distinctly disclaimed any intention of implying that the climate of Auburn differed from that to be found at many places in the foothills, both north and south, at similar altitudes, and presenting equally favorable conditions of drainage, good water, and sunshine. The altitude of Auburn, which is situated on the divide between Bear river, upon the north, and the American river upon the south, is from 1,000 to 1,300 feet. Its situation at that altitude made it frequently mentioned as "above the fog and below the snow." Its winter climate was unsurpassed in the State, and, therefore, on the continent. Facing the south, it received ample sunshine during the colder months, while the porous nature of its soil—a red loam—and the ample natural drainage, rapidly dried the ground after the winter storms. In summer the air, even in the hot months, was always bracing, and upon the hottest days, owing to the dryness of the air, invalids never experienced the depression accompanying high temperatures, the cool nights at that season always insuring refreshing sleep. During the time covered by the tables, snow that remained upon the ground had only been observed upon one day, and then remained without melting for 12 hours. Its practical freedom from fogs showed the superiority of this climate, as but seven days, annually, show traces of the winter fogs, which, for weeks at a time, will cover the great interior valleys. This fact was of great benefit in selecting a climate for asthmatics, as that disease is invariably aggravated by fog or greatly increased humidity. He had never seen a case of asthmatic trouble originating *de novo* in the foothills. In phthisis, where not too far advanced, marked benefit was usually experienced, but in the later stages it was wrong, and even cruel, to advise the sufferers to leave the comforts of their homes to seek relief in any climate. Cases of bronchitis, coming from the trying summer climate to this coast, do well, and generally need only a short sojourn in the drier atmosphere to produce a marked change. So rapid, in fact, was this amelioration that the subjects frequently returned to their homes before a permanent cure had been established.

DR. JOHN FIFE, of Red Bluff, who had been requested to open the discussion, said: I am not at all familliar with the climate of the foothills of the Sierras, as I live in the valley and do not feel competent to speak on it.

DR. J. H. PARKINSON, of Sacramento. Like Dr. Fife I live in the valley, but I cannot say I do not know anything of the climate of the foothills. In California we have so much good climate that we are apt to ignore the atmospheric advantages at our own doors in favor of those of some distant locality. The facts and figures Dr. Rooney has presented go to show that in the foothills, between an elevation of one thousand feet and the line of early snowfall, we have a location exceedingly valuable in the treatment of pulmonary complaints, not only where there are specific troubles of that character, but where a light, bracing atmosphere is needed and where the heavier air of the sea coast, or a more robust climate, would not be so beneficial. The one thing which, perhaps, is wanting to make the climate more generally adapted to the invalid is proper accommodations. Auburn possesses hotels of more than average character, as I can personally testify, but we need something more. We need a place especially adapted to invalids, containing the numerous accessories for their comfort that have been found a profitable investment in other States; and I hope the time will come when parties will find it to their pecuniary interest to create such an establishment, which I feel certain would be well patronized. Auburn presents many of the features desirous for such an establishment, and for several years past it has been the custom of physicians in San Francisco and in Oakland to send cases of bronchial trouble and of consumption in the early stages to that locality. As Dr. Rooney says, there is a belt of foothill country presenting similar climatic advantages; but the peculiar advantages of Auburn are convenience of access, good water, good drainage, and, I might add, excellent local talent in the medical profession.

DR. H. D. LAWHEAD, of Woodland: Not only pulmonary but nasal and laryngeal troubles are benefited by a sojourn in the climate of the Sierra foothills. In my limited experience I have had a number of cases which were greatly benefited by passing the summer or fall season there. Auburn, however, is not the only place which presents these advantages; there are many others of equal attractiveness.

DR. W. W. MACFARLANE, of Woodland: When in San Antonio, Texas, some twelve years ago, I met an old physician and I asked him why it was, in view of the fact that so many who had come there from 1830 to 1870 for the benefit of their health had recovered entirely, such was not now the case? His reply was "hotels." He said that from 1830 to 1860 and 1870 every one who came to San Antonio to be cured of lung trouble would ride a mustang all day and sleep in blankets under the stars at night; that that exercise and the sleep in the open air was the principal reason for their recovery; and that since they had built such fine hotels, with all modern improvements, all that had been done away with, and patients were but little benefited by the climate.

DR. N. WATTS, of Chico: Last season I had a very severe attack of bronchitis, and went to Bartlett Springs; was there five or six weeks and was cured. If I had a patient for whom I wished a change of climate for a month or so, I would send him there.

DR. O. ROHM: The same conditions that apply to Auburn apply to nearly all the foothill country, up to an elevation of 3000 or 4000 feet. I am practising on the Upper Sacramento, and bronchitis is almost entirely unknown there, except among persons recently from the valley.

DR. J. E. RODLEY, of Chico: I never saw a case of asthma in Chico or its surroundings, and I have been there for nearly seven years.

DR. WATTS, of Chico: I have known persons to come there from the East who were troubled with asthma, but after a short stay it would usually leave them, though sometimes they had to go to the mountains.

DR. J. S. CAMERON, of Red Bluff: I have been what I may call a "mineral spring sharp" for a number of years, and can testify to the virtues of a number of springs. For rheumatism, I should recommend Klamath Hot Springs; for kidney disease, Bartlett Springs; for skin disease, Tuscan Springs, and for dudes, Napa Soda Springs. Aside from the difference in the waters of the various springs, the climate in certain places suits certain conditions, and does not in others, and this must be studied in order to meet with success.

DR. ROONEY, of Auburn: I do not intend to claim any peculiar advantages for Auburn. What I claim for that place I simply back up with statistics of the climate there for a series of years. But there is one thing I would like to say in regard to any locality resorted to by consumptives. They will all, I believe, become infected with the tubercle bacillus. You never saw a consumptive yet but would expectorate in some open place where he could look at it. He will do that in hotel halls, on the porches and on the lawns; not in the grass, mind you, but on the paths. The expectoration dries up under the influence of the sun and wind and the next one who comes along inhales it. And if the soil is suitable, there is the germ that produces the crop. Therefore I fear, with the great accession of consumptives to this State, that the soil at places where they resort will become more or less infected with tuberculosis. In every cemetery where the consumptive is buried the worms will bring the germs to the surface. For that reason I am a strong advocate of cremation. No consumptive should ever be buried in the earth; the body should be cremated and all these germs destroyed. The sputum of a consumptive patient should alway be placed in a vessel and, if possible, burned, or thoroughly disinfected and buried. There are a good many of these things which must be attended to in the future. We must teach the people hygiene; teach them the proper way in which to dispose of the body after death.

Head or Brain Injuries.—S. J. S. ROGERS, of Marysville, read a paper on this subject, in which he discussed the relations of traumatism to epilepsy, more particularly in cases where the injury had preceded the disease by many years. He alluded to the Buchanan case, and also quoted from the well-known "crowbar" case as illustrating this point.

Dr. W. W. Macfarlane, of Woodland: I hardly know how to open the discussion except, beginning back of where Dr. Rogers commences, by saying that all cases of punctured or gunshot wounds of the head should be trephined, and all cases of fracture, whether there is depression or not, if there is serious brain complication manifested soon after in any way, should be trephined. If there is depression without brain complication, it is a question whether or not trephining should be resorted to. It is not the evident cases of fractured skull that are the most difficult to diagnose. Any one who sees a fractured skull generally knows what to do, if it is an open wound especially. But if it is what is frequently considered a slight wound, there may be no depression apparent but there may be brain trouble, that will ultimately, as the doctor states in his paper, bring on epilepsy; and cases of epilepsy caused from a depression of the skull will never improve—I have never known one to —but will constantly get worse as long as there is life. But if trephining is resorted to in these cases, and the skull be raised, the probabilities are that the person will get well entirely and will never have epilepsy. Otherwise, as the doctor remarks in his paper, though they may not have epilepsy for several years after, it, or some form of insanity, will ultimately come on. I have seen a good many cases of gunshot wounds and other injuries to the head. I remember one, the case of an old man who was a section hand on a railroad. He started to climb up the side of a cut in the winter time, and, it being slippery, fell back, and the cow-catcher of a passing train struck him and knocked out about three inches square of skull over his right eye. That man was taken on the train and carried into town, a distance of five miles, and there walked from the station to his boarding-house, a distance of about six blocks. He was never unconscious for a moment from the time he was hurt until he recovered; and he was entirely well when I last saw him, several years afterwards. I do not know what treatment he received, but that was before the days of antiseptics. It is in the cases that do not seem to be very severe, that you have to be very careful in making a prognosis. For example: A man received a charge of very fine shot in the back of his head, at a range of almost thirty feet. We could not find, by probing, where any shot had entered the skull, and the man seemed to be perfectly well as soon as he got over the sudden effect of the blow, and seemed so for five or six days. Suddenly he was taken worse and died in a few hours. It seems one shot, so small that the probe would not enter the hole, had gone into the skull. I recollect another case where a man was standing with his hand over the muzzle of his gun, with the butt on a railroad tie, off which it slipped, causing the charge to explode, tearing his hand very badly, filling his face full of shot and blinding one eye. I picked a very large number of shot from his face and from under his chin; and his hand healed up, and he was apparently well. But fifty-two days after the accident, he was taken suddenly ill with a very severe headache, and died in a very short time. I mention these two cases to show that we should be very careful in making our prognosis in brain injuries.

Dr. C. H. Gibbons, of Arbuckle: The following case is, I believe, unique in several respects. About ten days ago a boy twelve years of age, while running, fell toward a horse, which kicked, striking the boy on the left parietal bone, cutting a gash through the scalp and driving a triangular piece of skull, about one and one-half inches on each side, down into the brain. I was called to see the boy, and, of course, told them he would die in a few hours; but, wishing to do something, I put in a couple of stitches to draw the scalp together, and went home. The next morning I was again called to attend him, as they thought he was better. I went in company with Dr. W. H. Belton of Colusa, and found the boy without any signs of coma, his respiration and pulse being good. We concluded to try and raise the piece of bone. Chloroform was administered, and we found the bone wedged between the sphenoid and the side of the parietal bone; but, as the boy seemed to be sinking, desisted, to prevent his dying on the table. We told them he would probably die before night, and went home. The next morning we were again sent for. Not to go into further details, the patient recovered without any unpleasant signs or symptoms. He is now clerking in a store in Colusa. I asked his father lately if he saw any difference in the mental condition of the boy since the injury, and he told me he thought he was, if anything, smarter than before. The bone still remains in the boy's head. Dr. Belton considers it the most remarkable case of which he has any knowledge, with the exception of the familiar crowbar case. In attempting to raise the bone, when we opened the skull, probably one and one-half ounces of brain matter ran out on the table.

DR. ROGERS, of Marysville: The conclusions I wished to draw were mainly these: That we see a great many cases of epilepsy that we cannot easily account for, but, from what I have seen of epileptics, I am satisfied the foundation of epilepsy in after years is often laid in childhood by the carelessness of children in hitting their heads unusually hard when at play. We have all seen them do that; we have frequently seen them fall and lie for a few moments unconscious, or apparently so, and then get up and cry a little and go on with their play again. I have become satisfied that in many instances the concussion then received lays the foundation for epilepsy in after life.

The Dietetic and Therapeutic Management of Typhoid Fever.—THOS. ROSS, of Sacramento, in a lengthy paper upon this subject, said: The gravity of this disease, whose germs may live indefinitely in any climate, and under the most unfavorable conditions, together with its universal distribution, rendered the treatment of such a formidable affection of great interest to the physician. It is said that typhoid fever annually causes the death of fifty thousand people in this country, and it was certain the number of cases in any community was directly proportionate to the insanitary condition of the locality. The origin of the disease was now generally accepted, the source of infection in a great many cases being the water supply. Filthy surroundings and bad sewerage were favorable conditions for the development of the disease and the multiplication of its germs. Reliance should, therefore, not be placed upon pure water alone. In this disease the dietetic treatment was of paramount importance. Fluid foods, nourishing and easily digested, and leaving the smallest amount of waste matter to be carried through the intestine, were most appropriate. Among this class, milk is entitled to first place. It should be first boiled and then diluted with lime water. Fairchild's tubes afford an elegant and efficient means of preparing milk for the most delicate stomachs. Alcohol was a food in this disease, supplying oxygen and preventing tissue waste. It should generally be given in the second week. He discussed the therapeutic management of the disease under four heads: the antipyretic, antiseptic, hydro-therapeutic, and the symptomatic. The continued high temperature tended to depress the patient, as well as producing lowered tone in all the functions of the internal organs. The coal-tar derivatives have been highly extolled and extensively used in the treatment of typhoid fever; but, while lowering the temperature, they had no influence on the severity of the attack, and at the same time they depressed the action of the heart, already weakened. Quinine seemed to have no result whatever in influencing the temperature. Amongst the antiseptics, many had been recommended. Calomel, in large doses at the commencement of the attack, had been mentioned as mitigating its subsequent severity. The mineral acids seem indicated on physiological grounds. Beta-naphthol, in large doses, has been claimed to have greatly lessened the severity of the disease. The sulpho-carbolate of zinc was also an intestinal antiseptic. Reference was also made to the recent use of antitoxins, but sufficient experience had not as yet been afforded to test these results. The use of baths in reducing temperature, as well as the sedative effect of the water on the cutaneous surface of the body, had long been known, and it had been claimed that patients treated systematically during the first week showed a death rate of only one per cent. Cold baths, however, must be used with judgment, the presence of grave complications, as intestinal hemorrhage, contraindicating their use. This method of treatment was exceedingly difficult to carry out in private practice. The symptomatic treatment was the rational one to adopt in the management of the disease, being always careful to do no harm. Hyperpyrexia, tympanites, intestinal hemorrhage, diarrhea, constipation, epistaxis, headache and insomnia must all be met with appropriate measures. During convalescence, owing to the protracted character of the disease and its depressing effects, great care should be taken to guard against exposure to any injurious influence.

DR. O. STANSBURY, of Chico: The treatment of typhoid fever calls for good nursing and proper food more than medicine, and I think that is the grand step in advance that the profession is making to-day. It should be regarded, I think, as a self-limited disease; one that you cannot cut short. That has been my experience; and I think attention to proper nursing, putting the patient to bed early and keeping him there, are all important. I must admit that I am somewhat at sea with regard to the use of antipyretics in controlling the fever. With children I have used them with considerable benefit, but in adults they do not seem to act so well. There is one objection to them: you are unable to determine just how the fever is running. You are constantly lowering the temperature, and feel somewhat relieved to know it is kept down, when it is perhaps, due to the action of the drug, which at the same time is depressing. So I am disposed to discard their use and to rely on bathing and cold water applications, which I think control the temperature in the majority of cases. There is one thing I think good in the treatment of this fever, particularly in the Sacramento Valley. That is the moderate use of quinine. I admit I cannot control the fever with it, but it seems to have a good effect. I do not believe in giving it in heroic doses, but rather in keeping the patient somewhat under its influence for the first three weeks, or perhaps longer. The diet in these cases is all important; and milk, combined with lime water or with some mineral water, such as Napa soda, is the ideal. I give that freely. In these cases a great quantity of liquid is required. It is agreeable to the patient, and seems to flush out the kidneys and carry off the poisonous matter in that way. By proper attention to the diet, we get rid of the tendency to diarrhea. I think of late years there has been a tendency to discard the use of chicken broth and beef tea, on which we formerly relied principally; and when we did that, we had a great deal more trouble with diarrhea than we have now, when we use milk so extensively. Intestinal antiseptics are good where there is diarrhea and very offensive discharges. You should then give some intestinal antiseptic, such as hydronaphthol, which is excellent, a very few doses removing the offensiveness. I do not believe in the use of stimulants, as I think they are generally an injury to the patient. In some cases, where you have a weak condition of the heart, it is of course absolutely necessary to give them, and to give them freely; but unless there is some trouble of that kind, I doubt very much whether it is beneficial to commence them in the early stages of the disease. In the later stages, where the patient becomes very weak, stimulants are good.

Dr. J. H. Parkinson, of Sacramento: There are complications in typhoid fever that always demand special treatment; but with the profession to-day attention to the diet, the use of antiseptics, and some method of lowering the temperature, are the leading features in the management of this very serious disease. The author of the paper mentions milk, plain, and combined with an alkali, as a suitable diet. The first, I have frequently used; and prepared by peptonizing with the Fairchild digestive tubes, it is an ideal diet. I prefer also to give, as a precautionary measure, some intestinal antiseptic as hydronaphthol, frequently combined with salol. In controlling the temperature, from my limited experience, I must say I differ with the author of the paper and with the last speaker. I have had extremely satisfactory results, both with adults and children, from the use of phenacetin, giving it, of course, with that watchful precaution which should govern the administration of any such agent, but giving it continuously. I think the patient has more comfort, and I always feel that the complications we frequently meet with in such cases are less likely to arise with the temperature kept at about 100° F., than when allowed to range higher. It is true that where giving the drug continuously, we are ignorant of the real temperature. But there are two methods by which this objection—to which I attach no particular weight—may be overcome: One, by suspending the administration of the drug for a period of hours; another, by noting the amount of the drug necessary to keep the temperature at about that figure. If that amount be small it may be taken as an indication that the temperature, without the drug, would not be ranging high. But if it requires large doses, then it is tolerably certain that the temperature, were it not for the remedy, would range high. The only objection I have found to the drug in practice is the rather profuse diaphoresis that ensues; but I think that is much more than compensated for by the refreshing sleep, the lack of headache and the clearer intelligence of the patient, and the satisfaction to both patient and relatives which absence of delirium produces.

The President: For the past two years I have treated typhoid fever systematically with phenacetin, and an experience of 51 cases compels me to dissent most emphatically from the statement made, that it is one of the diseases in which medicine should be used sparingly. Beginning two years ago this coming November, there prevailed in Sacramento an epidemic of typhoid fever. Previously to that, I had used phenacetin, as I believe most physicians now use it, whenever the temperature exceeds a certain maximum—say 103° or 104° F.—but my results from its use left a great deal to be desired. In the first place, the patient sweated profusely, which was unpleasant, to say nothing more; in the second place, as the temperature rose again a chill occurred, which was also unpleasant, and, I believe, deleterious. So two years ago I began to use phenacetin regularly, every two or three hours, in doses sufficient to keep the temperature at about 100°. Occasionally that was impossible, and the temperature would go up to 102°, or even 103° F., for an hour or so in the afternoon and evening. I would then increase the phenacetin up to 10 grains, if necessary, every two or three hours. That may seem a very large dose, but it is the dose I have been accustomed to give; and that I gave in a majority of the 51 cases referred to, not only without a single death, but without any serious complication or sequence. That is, I think, an unusual record for such a number of consecutive cases. Phenacetin does several things: It reduces the temperature promptly; it soothes the nervous system. The patient who, with a higher temperature, is restless, quiets under phenacetin, feels comfortable, and no longer is a source of anxiety to his friends. Not only does it soothe, but if the temperature is kept down near 100° the patient generally—except in those cases which we call gastric, where the stomach is very irritable—will want a greater range of food than the physician is inclined to allow. Delirium is absent. In the 51 cases I have not had any delirium, except in the first case, and that had run for two weeks before it came into my hands. In that case the patient was delirious at the time I took charge, and for several days afterward. In the rest of the 51 cases, delirium did not occur at all. Besides relieving the symptoms mentioned, the use of phenacetin keeps up the digestive powers of the patient; because, if the temperature is kept down, the secretion of the gastric and intestinal juices, which are the best antiseptics, goes on without interruption. It has been said that antipyretics, and particularly those derived from coal tar, impair the strength of the heart's action, and that they are dangerous in typhoid fever. That is undoubtedly true of several of them, particularly of antipyrin, and in a smaller degree of acetanilid; but I believe phenacetin is wholly free from this charge. I have now on my records 3 cases of typhoid fever, among the 51 cases referred to, where there was a relapse and where I administered phenacetin in 10-grain doses, every two or three hours, for about six weeks, and the heart tone was excellent during all that period. If the heart shows any sign of lowering of tone, combine the phenacetin with digitalis and it will serve every purpose. Diaphoresis, which one member has spoken of in the discussion, is wholly obviated by the continuous and full effect of phenacetin. With that continuous and full effect, you have no more sweating with a typhoid fever patient than you would have with a person in ordinary health. If you allow the patient to come partly out from under the influence of the phenacetin, and then give a full dose, you will have a very profuse and most likely a very debilitating sweat. As to intestinal antiseptics, I will not say I have wholly discarded them, but still I fear them. I have seen two cases of marked collapse from 30 grains of salol, given during 24 hours, in 2½ grain doses every two hours, or 3¾ grain doses every three hours; and I believe in this disease you will be more likely to get renal irritation and smoky urine from salol, because the kidneys are taxed to their utmost with the products of retrograde metamorphosis which are passed largely through them, and if you add to those products an irritating drug like salol, you will be likely to set up a condition of the kidneys which will be detrimental to your patient. Quinine I believe of very little use in typhoid fever, unless there be a malarial complication. I must confess that in the cases referred to I have not administered quinine more than four or five times, and then only at the outset, when I suspected a malarial complication. The dietetic and hygienic management of this fever is, of course, of the utmost importance; and I would not for a moment have you infer from what I have said, that I belittle it. On the contrary, I observe the same rules that I presume all of you do in regard to diet, in regard to rest, both mental and physical, and in regard to the condition of the digestive canal generally. But from an observation covering 51 consecutive cases, I must say that I have the utmost confidence in phenacetin relieving the unpleasant features of typhoid fever. In some cases, giving 10 grains every two or three hours, you will have a slight blueness such as you have in the administration of acetanilid, and at first this inclined me to diminish the dose of phenacetin; but now I pay very little attention to it, and now frequently a patient under my care with typhoid fever is slightly bluish for several days. This may seem extravagant, but the experience I have had makes me very strong in the conviction that the reduction of temperature by phenacetin is a distinct advance in the therapy of typhoid fever. Recently I have seen that lactophenin has been employed for the same purposes: reduction of the temperature and calming of the nervous system; and German observers are even inclined to think, if the reports are correct, that it abridges the disease; but I think that will prove to be an error. I believe it will be found to have very much the same effect as phenacetin, and I have not observed that phenacetin abridges typhoid fever for a moment. It prevents complications and sequels, but the disease itself I do not believe is cut short by it.

Dr. T. P. **Peary**, of Yuba City: I have never attempted to abridge this disease, nor to prevent the temperature from rising until it got above 102° F., when I used cold water; and where I could not keep it down in that way, I used antipyrin, giving one or two doses—just enough for the occasion. We all know, of course, that antipyrin has the objectionable features mentioned. I have been in the habit of giving quinine occasionally, but not in large doses. In the beginning it was likely to require a few days to determine whether it was malarial or some other fever. In such cases, supposing it to be malarial fever, I have given quinine, and calomel to clear out the alimentary canal; after that, I have continued the quinine, in small doses, combined with chlorate of potash and opium—something that may be deemed objectionable, perhaps, as impairing the digestion, but I find it soothes the system and acts better than quinine alone in toning it up. Where the temperature ranges at 101° F., or even less, I have never found any necessity for the incessant use of antipyretics, but I find a little opium quiets the nervous system and makes the patient tolerate the disease better. While the use of antipyretics is deprecated because of being depressing to the heart, there is an excuse for their employment, from the fact that they keep down the extreme temperature, and nothing is more depressing to the heart's action than high temperature itself. I have, therefore, used them right along. I have used them the second week, when the heart sounds became faint.

Dr. R. F. **Rooney**, of Auburn: In the mountains we apparently do not have any cases of typhoid fever. I do not think in Auburn and vicinity we have more than 4 or 5 cases in a year, and when those come to be divided up among the local practitioners, it does not average one apiece. Our experience with the disease is, therefore, not extensive. But the cold and uncompromising statement of our President, that he has used phenacetin in more than 50 cases, with an agreeable effect on the patient, an avoidance of diaphoresis, and an unfailing cure, has stirred me up, and the first case of typhoid fever I have I am going to try it, even if it be opposed to the general ideas of the profession as I understand them now. I give much weight to the views of the President, from the fact that he has used it so continuously and with such invariably good effect. But if the patient I try it on should die under the treatment, I shall blame the President for it.

Dr. W. E. **Bates**, of Davisville: I shall come to the rescue of the President. I have used the same remedy for the last three or four years, both in typhoid fever and in pneumonia. Phenacetin has a most salutary effect. Occasionally I have been called in consultation, and have given it to a patient who had not been using it before, and the change has always been immediate and satisfactory to him and to his friends.

Dr. H. D. **Lawhead**, of Woodland: Hearing of the great success from the use of phenacetin regularly and systematically in cases of this kind, and soon after having a case of typhoid fever, I tried it. Being afraid of 10-grain doses, however, I tried 8-grain doses. But the patient became cyanotic, and remained cyanotic, and died. That may not have been due to the treatment, and, perhaps, it was not undertaken soon enough. I only mention it because the President himself advises us to be discreet in the beginning in the use of phenacetin. It seemed to me that, while diaphoresis was very marked from the use of phenacetin, the other secretions seemed to be in abeyance, and that, while the urine was very heavily loaded, the quantity voided was less and the color higher, and those conditions present caused me to suspect that its action was not alike stimulating to the various secretions of the body. In giving drinks, where you want to cool and satisfy the patient, I have sometimes found very great help from the use of flaxseed lemonade. The patient can tolerate it very well, and sometimes it will be very soothing to him.

Dr. J. E. Rodley, of Chico: I would like to ask the President if, in the 51 cases of typhoid fever he treated so successfully, he used any treatment other than phenacetin.

The President: No other stomach treatment and no other antipyretic, except sponging with alcohol, which has been used almost uniformly.

Dr. Rodley: I should be afraid to put a patient on phenacetin and have him continue on it. I have treated a good many cases of typhoid fever, and I have had a reasonable amount of success. My treatment, when I am satisfied that I have a case of it on my hands, is this: I put my patient on sulpho-carbolate of zinc, 2-grain doses every three hours. If the temperature is high in the afternoon, which it generally is, I leave instructions to give quinine with digitalis. I combine it in a fluid mixture and give them together. Being afraid of the effect of quinine on the heart, I never allow it to be given constantly; but wherever there seems to be a rising in the temperature, I leave instructions to give it if the fever comes up to 103°, and to keep it down below that with it. I find in all cases that I get better results and less bowel trouble, when I use the sulpho-carbolate of zinc. In the diet, I use cream. I discard milk; I am afraid of it. The amount of casein that milk contains, causes it to form masses in the bowels that may give rise to trouble; consequently, I give cream and get better results from it. It is very nourishing; it contains hardly any casein, is easily digested, and is more strengthening than milk.

Dr. T. W. Huntington, of Sacramento, read a paper on "Tenorraphy, with a Report of Four Cases" [published at p. 644].

Dr. W. E. Bates, of Davisville: In secondary operations for tenorraphy, it is recommended that the incision through the skin be made either above or below the incision in the tendon, so that the two scars will not unite, but be one above the other. There is another method of elongating the tendons, recommended by a German authority. Instead of cutting clear through, as Dr. Huntington showed in his illustration, I will send around one which shows a partial incision, which makes an S shape on the tendon. In that way there is a continuation of the tendon. Harris, of Chicago, in uniting these tendons, prefers the finest silk possible, and in carrying the needle through, pulling the ends as close together as possible, and burying the knot between them. Of course he insists that the thread must be perfectly aseptic, and it must be as fine as possible, and yet strong enough to hold with what he believes the proper tension on it. He uses a round needle, an ordinary sewing needle, for that purpose. In some cases of tenotomy, the tendon can be attached to that of another muscle, with satisfactory results.

Gangrene of the Scrotum, with Erysipelas.—T. W. Serviss, of Oroville, reported this case and exhibited photographs of the condition. The patient, a miner, aged 49, was admitted to the Butte County Hospital, January 12, 1894. The scrotum was immensely swollen and black, with a fetid odor. The penis was also swollen, and paraphimosis, with a gangrene of the skin on the right side, including one-half the circumference and extending the whole length of the organ, was also observed. The erysipelatous inflammation passed up upon the abdomen as high as the umbilicus and down upon the thigh to the middle third. There was a diffuse abscess in the cellular tissue of the abdominal wall above the pubis. From this a quantity of fetid pus and gangrenous areolar tissue was evacuated. The parts were dressed with a bichloride solution (1:2000). In about one week, the scrotum, together with the skin on the right side of the penis came away, leaving both testes exposed, and an opening into the urethra at the base of the penis about the size of a ten-cent piece. The abscess cavity above the pubis now discharged along the cord on the right side. The parts were dressed with aristol, being first irrigated with a weak bichloride solution.

In about three weeks the testicles were covered with granulations. The left testicle was drawn up into the external ring, the right testicle was covered by a small piece of the skin remaining on that side, which gradually extended over. The other complications in the case were now taken up, but before a cure had been effected, the patient left the hospital.

EVENING SESSION.

Treatment of Gonorrhea by Retrojection.—W. J. Hanna, of Sacramento, read a paper upon this subject. He first discussed the etiology of the disease as well as its bacteriology. The gonococcus was recognized as the specific cause of the disease. The discharge of infectious urethritis, due to other causes and running a much milder course, being free from this specific organism. The ordinary method of treating gonorrhea by injection included almost every remedy in the materia medica. The tendency of this injection was to carry the products of the inflammation backward along the canal, causing numerous complications. Continuous irrigation had been tried as early as 1864, but it had not proved successful, and later, retrojection with an ordinary catheter and bulb syringe had been found very satisfactory. The object to be gained by retrojection was the complete distension of the urethra with a mild antiseptic fluid, the constant current of which at the same time washed away the products of the inflammation. The necessary apparatus consisted of a reservoir, a connecting tube, and a urethral tube having a bulbous tip with openings directed backward. This tube, well oiled, is then passed down the urethra for a distance varying with the stage of the disease, and one to two quarts of a listerine solution (3 to 6 per cent.) was allowed to flow through the tube. At times during the flow the patient was instructed to compress the end of the urethra so as to thoroughly distend the canal. The irrigations should be repeated at least once in the 24 hours. In acute cases, begun early, the character of the discharge would change in a few days, after which the irrigation is discontinued, and a solution of zinc chloride (2 grains to the ounce) is passed through the retrojection tube by means of a syringe, 4 ounces of the fluid being used. The result of this method of treatment was to allay the inflammation, as well as to modify the discharge, so that the disease, as a rule, is cured within two weeks.

Annual Address.—The President, W. A. Briggs, of Sacramento, read the Annual Address [published at p. 637], which, owing to his absence at the morning session, had been postponed till the close of the meeting. He had taken as his subject "Misplaced Pregnancy, with a Report of a Case," entering at some length into the pathology of this condition.

Secretary's Report.—The Secretary, E. E. Stone, of Marysville, submitted his annual report. He said the Society had been organized a little less than four years, during which time the membership has had a steady growth. At the first meeting, in Marysville, May 26, 1891, there were 18 members; there were now 53. The Society has held its meetings in Marysville, Chico, Biggs, Sacramento and Woodland, and the proceedings have been published in full in the Occidental Medical Times, the official organ of the Society.

Treasurer's Report.—The report of the Treasurer, O. Stansbury, of Chico, showed that the Society had received during the year $129.00, and disbursed $123.15, leaving a balance on hand of $51.30.

Place of Next Meeting.—An invitation from the San Joaquin County Medical Society, requesting that the District Society hold its next meeting in Stockton, was presented by the Secretary. On motion, the invitation was unanimously accepted.

Election of Officers.—The Society then proceeded to the election of officers, with the following result:

President	H. D. Lawhead.
First Vice-President	John Fife.
Second Vice-President	T. P. Peary.
Third Vice-President	A. W. Hoisholt.
Secretary	E. E. Stone.
Treasurer	O. Stansbury.
Board of Censors	W. E. Briggs, W. E. Bates, G. W. Stratton, T. B. Reardon, Thos. Ross.

Installation of Officers.—The regular business of the meeting having been concluded, the retiring President, W. A. Briggs, of Sacramento, in a brief congratulatory speech, introduced the President, H. D. Lawhead, of Woodland. Dr. Lawhead, in replying, expressed his earnest intention of devoting every energy to the advancement of the interests of the Society, and assured his audience that any failure on his part would only be due to lack of experience. The Society then formally adjourned, to meet in Stockton on the second Tuesday of March, 1895.

New Members.—At the different sessions the following were duly elected members of the Society:

J. H. Barr,
J. C. Cameron,
John Fife,
I. S. Jadaraloa,
S. B. Littlepage,
J. A. Randolf,
J. T. Rohm.

SPECIAL CORRESPONDENCE.

BERLIN.

The Feriencurse.—Post-Graduate Instruction at Home and Abroad.—Nitze and Cystocopy.—Catheterization of the Ureters.—The Urethroscope and Its Practical Application.—The Janet Method in Gonorrhea.—The Estimation of the Pus Corpuscles in Genito urinary Diseases.—The Pathological Institute.—Phaneroscopy.

The "Feriencurse" for physicians began on the 24th of last month and will continue until the 27th of September. Two such courses are given each year. Instruction is usually intrusted to assistants who have a prodigious amount of material at their command. Extra mural instruction is also given by many physicians not connected with the University of Berlin. The Germans are properly educated with reference to hospitals, and are exempt from that false prejudice which prevails in our country. Private clinics are abundant. To my knowledge there are about 20 of these in Berlin. The specialist here, inaugurates his career by establishing a polyclinic, which conveys the meaning, that special hours of the day are reserved for the treatment of the indigent poor. The upshot of the entire matter is, that one specialist vies with the other in accumulating the greatest amount of material, bestowing little regard to the financial status of his patient.

I have in a previous letter made a comparison between the post-graduate courses in London, and those in many cities of the United States. The views then expressed are equally applicable when Berlin is taken as a standard for comparison. No American physician, unless in exceptional instances, or to attain the prestige attached to European medical education, need go beyond the confines of the United States for post-graduate medical instruction. At home this is systematized, while here the courses correspond in a measure with the preliminary sessions of under-graduate medical schools in the United States. That this fact is amply recognized, is illustrated by the comparatively limited migration of American physicians to Europe, for the purpose of medical study. It is undeniable, that in many branches, as physiology, bacteriology, and pathology, the home market is still unproductive. The practical physician, however, has neither the time nor the inclination to pursue the details of branches which he recognizes as theoretical. The essentials of physiology, pathology and bacteriology he can learn at home. When I worked in Prof. Arnold's laboratory in Heidelberg ten years ago, it was known as the "American Laboratory." At that time the Americans frequently exceeded the Germans in number, and Heidelberg always has been a favorite rendezvous for American physicians. In a conversation with Prof. Arnold a few weeks ago, he assured me, that the number of American physicians who did work in pathological anatomy at his laboratory was diminishing each year. This falling off in attendance, he attributed to the improved facilities for such instruction in the United States. "When the professors of such branches as anatomy, physiology and pathology," said he, "can devote themselves solely to their respective subjects, the preëminence of American medicine will be assured."

Among the many special practical branches taught during the "Feriencurse," perhaps the most novel is that of genito-urinary surgery, which includes, of course, the use of the urethroscope and cystoscope. The man who has attained special prominence in this line of work is Nitze, a privat-docent at the University. To him, in fact, is due the practical applicability of the cystoscope. His dexterity with the instrument is such, that he is not content with a mere illumination of the bladder for diagnostic purposes, but he essays to do things which to others is almost impossible. He catheterizes the ureters with his special cystoscope, and by means of his operating cystoscope, he removes growths from the bladder with the same certainty as could be accomplished by sectio alta. I saw him remove a polypus from the bladder by means of a snare, in the case of a man who suffered from hematuria. Aside from the many advantages of such an operation, for both physician and patient, the observer regarding the maneuvers from an artistic standpoint, simply marvels at the completeness of his manual dexterity. He has, thus far, refrained from publishing the results with his operating cystoscope, fearing no doubt the misuse to which this instrument would be put in unskilled hands. He is pedantically aseptic in his operations, and he is modest enough to attribute much of his success to that fact.

Kidney surgery has been revolutionized by the use of the cystoscope. By means of a specially constructed cystoscope, he can introduce a catheter into the ureter and is thus able to separate the urine from either kidney. This manipulation, as is well known, has, heretofore, only been accomplished successfully in the female. The cystoscope will also furnish evidence of the existence of two kidneys as well as of their action. This fact, apparently unimportant, is of the greatest value. I vividly recall the case of a gentleman in the precystoscopic period, who was operated upon by an eminent German surgeon for a pyonephrosis. This gentleman had unfortunately only one kidney, and that was the one which was removed. In many cases of pyuria or hematuria of renal origin, the descending pus or blood so obliterates the field of vision, that it is often impossible to formulate conclusions from cystoscopic examination. This inconvenience is obviated by an irrigation cystoscope invented by Nitze. The latter has recently published a cystophotographic atlas containing sixty photogravures of the interior of the bladder. This photographical reproduction of the interior of the bladder by means of the photographic cystoscope, are not artificial, but reproduce the actual appearance of the bladder interior. The advantages achieved by cystophotography are manifold. In the first place, photographic reproductions of cystoscopic pictures will prove of great value for educational purposes. A good photograph will prevent mistakes or misinterpretation. Photographs will give a graphic record of the evolution or involution of a pathological process. They will also furnish evidence of a pathological condition, which could not be achieved by description, however diffuse.

The urethroscope, notwithstanding its extensive employment, still continues to prove of little practical value to the physician. Thus far, its real use has been limited to the anterior urethra, and as most of the pathological processes in this part of the urethra are submucous, they elude inspection. Circumscribed affections of the urethra, however, such as ulcerations and new growths are only demonstrable by aid of the urethroscope. The most serviceable urethroscope is the simple glass tube of Posner, through which light is thrown by means of a concave mirror from an Argand burner. The results attained by this simple means are equally as good as those achieved by more complicated apparatus. The original urethroscope of Nitze, with which illumination was secured within the urethra by a heated platinum wired, is no longer employed by him.

The pathogenesis of the gonococcus has been fully established, but as yet all specific remedies recommended for gonorrhea have proved futile. The best treatment now, as before, is the prophylactic. Ricord"s observation, "Une chaude pisse commence, Dieu le sait, quand elle finira" is equally applicable at the present day, notwithstanding the progress made in the pathology of gonorrhea. At the genito-urinary clinic of Posner, a routine treatment for gonorrhea is the Janet method, which consists of irrigating the anterior urethra (in anterior urethritis) with many liters of a solution of permanganate of potash (1:4000). The strength of the solution is gradually increased until a strength of 1 to 1000 is reached. The solution is preferably warmed before being introduced. A simple contrivance enables the solution to escape continually after it has fully passed through the course of the anterior urethra. In the beginning it is advisable to irrigate twice daily, and, as the strength of the solution is increased, once daily is considered sufficient. Janet's has yielded better results at this clinic than all other methods of treatment. In urethritis posterior a catheter is carried beyond the compressor urethræ, so that the solution may reach the posterior urethra.

At this clinic the pus corpuscles are enumerated by the Thoma-Zeiss counting apparatus. This enumeration attains two objects. (1) It enables us to estimate the severity of a catarrh of the urinary bladder. (2) It permits us to calculate whether the albumin present in the urine is due wholly to pus, or to a possible renal complication. In bladder catarrh of moderate severity, there are from 20 to 40,000 pus corpuscles in a cubic millimeter. In severe cases, the number counted may reach 100,000. The quantity of albumin present in the urine when due to pus alone, is estimated to amount to 1 pro mille to 100,000 pus corpuscles in a cubic millimeter. Supposing the urine to contain 40,000 pus corpuscles in a cubic millimeter and the albumin present to amount to 2 pro mille, then the latter cannot be due to the liquor puris alone, but must originate from some other source.

Interesting courses can be had at the Pathological Institute, and one can profitably occupy the entire day in the study of pathological anatomy. The courses are given by the assistants of the institute who always have an abundance of material at their command. This is furnished by the Charité, the largest hospital in Germany, which contains 2,000 beds. Thus, at one lecture on intestinal ulcers, Dr. Jürgens demonstrated fresh material illustrative of the subject derived from at least five different subjects. The Pathological Institute founded in 1856, has exerted a profound influence on the development of modern pathology. It was while Virchow was at this institute that he published his "Cellular Pathology." Here it was also, that Cohnheim demonstrated the migration of white blood corpuscles from the blood vessels; that Obermeier discovered the spirillum of relapsing fever, and Liebreich discovered the hypnotic action of chloral hydrate. The Pathological Institute is a disappointment. It is a crude structure and compares unfavorably with many similar institutions in Germany. The crude institute, with its appurtenances equally crude, may survive the illustrious and modest Virchow, but it is equally true, that a modern building is a necessity.

A new method of diagnosis described by Liebreich and denominated by him, "phaneroscopy" is entitled to some consideration. The principle is simple, and consists of concentrating on the skin by means of a plano-convex lens of large aperture, the light from a lamp of medium intensity. This method differs from diaphanoscopic illumination, as in the latter method, the object illuminated is between the light and the eye of the observer. Diaphanoscopic illumination is too diffuse and does not admit of a differentiation of the tissues. Phaneroscopy is combined with glass pressure (vitropressio). If pressure with the finger is made on the skin, any pathological condition which may be present, will escape observation. This objection is eliminated by the employment of pressure with glass. The combined method of phaneroscopy and glass pressure, permits of the detection of a lupus nodule, which would prove impossible by any other means (optical isolation of lupus nodules). The combined method also enables us to determine the situation of the nodules in the skin. Although phaneroscopy is suggested as a method of diagnosis for lupus vulgaris, it is destined to prove of signal value to the dermatologist in many affections of the skin. A. ABRAMS.

BERLIN, October 5, 1894.

GERMANY.

[FROM OUR OWN CORRESPONDENT.]

Deaths in the Profession.—Hermann von Helmholtz.—Cholera.—An Infant Prodigy.—Legal Difficulties.—A Fight for a Tooth.—Obstetrical Hints.—The Position in Parturition.—Optional Sterility.

During the last few months deaths in the profession have been deplorably numerous. First, there died at the ripe age of 84, Prof. Heinrich Bidder, for many years lecturer on physiology at the University of Dorpat, who, although belonging to this Russian university, was, by reason of his studies in Germany, his publications, and his numerous connections with the Fatherland, always reckoned as a member of the German republic of scientists. Besides, during his term of office Dorpat was essentially a German university; it is only lately that things have changed there, the foreigners having been supplanted by Russians of pure blood, and the former name having now been altered by an imperial ukase into Jurjew. One of Bidder's sons is at present a well known surgeon in Berlin. He himself was principally esteemed for his researches on the chemistry of the digestive juices and the coagulation of blood. Then, in Berlin we have lost Prof. Oscar Fraentzel, one of the most prominent physicians of the university, holding at the same time an important position in the sanitary corps of the Prussian army. His chief works treat on diseases of the heart, in which he followed to some extent on the lines marked by his late teacher, Traube, and on affections of the pleura. I cannot refrain from also mentioning Dr. Heinrich Hoffmann, of Frankfurt o. M., for, although not so renowned on purely scientific grounds, he was one of the most universally esteemed and best known writers in the land as the author of "Struwelpeter," or the "Untidy Peter," a nursery book of rhymes and pictures. I believe there is not a child in the Fatherland that does not know and delight in this book; and the impetus which it has given to providing our little ones with books adapted to their infant understanding has undoubtedly proved a perfect blessing to millions.

We have to record with the deepest regret the death of Hermann von Helmholtz, who died from a profuse hemorrhage of the brain (right hemisphere), on the 8th of last month, at Charlottenburg, near Berlin, at the age of 73. Helmholtz's name is too well known throughout the world to render any eulogy necessary, and, although in the latter portion of his life his researches related more to physics and the other natural sciences than to medicine proper, he has done so much for this department, both directly and indirectly, that we can but speak of him with the most heartfelt gratitude. His most popular discovery is no doubt the ophthalmoscope, which produced a perfect revolution not only in ophthalmology but also in our knowledge of the nerves, and of other affections as well. The first description of this invaluable instrument appeared in 1851, under the title, "Description of an ophthalmoscope (eye-mirror) for the examination of the retina in living subjects." The manner in which he speaks of the circumstances attending the discovery is highly characteristic of his modesty, no less than of his wonderful acumen. As professor of physiology at Königsberg, when he was about to explain to his audience Brücke's theory of the reflection of light from the eye, he was desirous of demonstrating this more clearly by a practical experiment, and being fully convinced of the correctness of Brücke's views, he argued that the only thing wanted was a system of lenses and reflectors in order to get hold, visually, of the reflected picture of the background of the eye. He says that good luck played an unproportionately greater role in this matter than his own merit. But it is clear that he does himself an injustice in this respect, especially as he goes on to say: "Without the firm theoretical conviction that it must be possible, I should, perhaps, not have persevered; but in a about a week I had the great pleasure of being the first to see a living human retina before me." The original ophthalmoscope was a somewhat cumbersome apparatus, constructed of spectacle-lenses and cover glasses, but it fulfilled its purpose and soon grew into the handy form in which we all know it. Truly one can say of him: "*Exegit monumentum aere perennius.*"

Cholera has again been threatening us for the last few months, but, although a number of cases have occurred during the latter part of the summer, we do not seem to be in any imminent danger at present, and now that winter is drawing near even the most pessimistic of hygienists, who had prophesied a speedy return of the Hamburg epidemic, have become calmer. This favorable result is mainly due, no doubt, to the measures adopted by the authorities for the supervision and isolation of all suspicious cases, for quarantine, in the ordinary sense of the word, has not been practised at all. All immigrants, however, especially those coming from Russia, have been carefully examinad by a complete system of medical inspectors distributed on the Vistula, at Hamburg, and at other points of entry to the empire, and no case seems to have been allowed to pass undetected. An animated discussion on this subject took place recently, at the meeting of the Society for Public Health at Madgeburg, though the great fight which raged between the "Contagionists" of the Berlin school, with

Koch and his ardent adherent, Fraenkel, on the one hand, and von Pettenkofer and Emmerich, of Munich, on the other, has gradually lost much of its ardor. The most prominent features of Koch's address on this occasion may be summed up as follows: "The comma bacillus is a necessary factor in the production of the disease; there are a number of other conditions which must also exist before cholera can be produced, some of which are known to us, while others are still an unsolved problem. Conceding, however, the necessity of the presence of a microörganism, we are at once in possession of a means of setting the influence of the unknown agents at nought by destroying this one link of the chain by killing the microbe." The practical results obtained by the measures adopted on these theoretical grounds are certainly a confirmation of Koch's ideas; and he is probably quite right when he continues: "We know that we cannot effectually prevent the introduction of cholera within our frontiers; the greatest weight must, therefore, be laid on counteracting the danger when it arrives. International measures of protection are comparatively futile. The best international protection would be for each State to adopt the plan we are following, viz.: to combat the disease by sanitary arrangements, and to stamp it out by breaking the chain of insanitary conditions requisite for its production."

A remarkable phenomenon is being at present exhibited (naturally for lucre) in Berlin, viz.: Otto Poehler, of Brunswick city, a child of less than two years of age, who is able to read various kinds of type. This is not a swindle, but plain truth. The boy learned to speak very early, we are informed by the father, a reputable butcher of the town, and when hardly a year old he began almost of his own accord to learn to read. He used to get the headings to the illustrations in books and on pictures read to him, and very quickly remembered the meaning of the printed characters; then, when a word with which he was acquainted was named he would look to find it in his books. Gradually he began to spell other words that he did not already know by hearing, and showed great curiosity to make out the meaning of all printed matter that came to his notice, placards, street signs, titles of books in shop windows, etc. He has now attained a remarkable proficiency. In reading he does not pick up one letter after another, as school children do, but takes in a general impression of the whole word-picture at once, almost the same as any one used to reading does. It will be interesting to observe the further career of this youthful prodigy. Very likely, though, his future development will be more or less impeded by the unusual strain of intellect to which he is now subjected.

An interesting legal controversy arose the other day in connection with one of the Hamburg hospitals. A child had been admitted suffering from tuberculous osteo-myelitis of the foot, for which, after several other remedies had proved ineffectual, resection appeared necessary. The father of the child, however, after much wavering, said that he would rather remove her from the hospital. As he let several days go by without doing so, and had not seemed in reality so much opposed to the operation, the surgeon in charge, Dr. Waitz, determined to operate, hoping to obtain the necessary acquiescence afterwards. On the day of the operation the father returned, but as the child was already anesthetised, he was told it was too late now. At first he made no objections, but several months later when the child was in excellent health, after a secondary amputation performed at the same hospital and with his complete consent, he suddenly entered proceedings against Dr. Waitz, on the plea of injuries and mutilation of the limb having been done to the child. In the first court he was unsuccessful, but on appeal he obtained a decision in his favor. A great deal of discussion has naturally arisen on the subject. The weak point for the lawyers in this case is that the decision bases on a paragraph regarding injuries wilfully inflicted by means of instruments, especially knives, etc. Now, it is quite obvious that it is utterly absurd to class a surgical operation as a corporeal injury, especially when, as in this case, the result has been a positive gain to the patient, but no surgeon has the right to cure any one against his will, or against the will of his legal guardian. Evidently German law is somewhat defective in this point, and in any case it behooves surgeons not to let themselves be carried away by any *furor chirurgicus.*

Another peculiar case occurred lately in Gera, and has not yet been definitely decided. A gentleman who had suffered for some time from toothache consulted a dentist, and on his advice consented to have the offending molar extracted. This was skilfully effected, not without some trouble, for the tooth proved to be a perfect monster in size, with roots measuring as much as two centimeters. The dentist was naturally desirous of preserving such a trophy, and, although the patient claimed the tooth as his property, refused to part with it. An action was accordingly commenced on the charge of defraudation, the defendant claiming he acted by the right of a time-honored custom, and that the tooth on being removed was a *res nullius*, and belonged to the first who took possession. I am afraid this will prove quite a difficult quibble to settle.

It is a common reproach to the Germans that we are too apt to be led estray from the paths of common sense by theories and dogmas. This was especially true of the application of antiseptics to obstetrical practice. Since Ignatius Semmelweiss (to whom a well merited tribute of gratitude was paid at the recent meeting at Buda Pesth) showed that puerperal fever is due to infection by external agents, the tide of public opinion amongst obstetricians has even overswept the mark which that pioneer labored to attain. When bacteriologists had demonstrated that pathogenic germs are often to be found in the genital tract of apparently healthy women, it seemed as if there was to be no limit to the attempts made to sterilize these organs externally and internally. In the Handbook of Midwives, edited by Leopold, of Dresden, instructions are given to flush the vagina repeatedly during labor; and a number of other rules are laid down, which will no doubt prove unwelcome to the patient and unpleasant, and even impossible for the midwife to carry out strictly. In contrast to all this, it is exceedingly gratifying to read the reports published by Dr. Mermann on the manner of proceeding at the Lying-in-Hospital at Mannheim. For several years past his plan has been to avoid all internal disinfection of the parturient canal, and only to lay weight on perfect asepsis of the surgeon's or midwife's hands and instruments. His publications comprise 1,300 cases; among the first hundred he had one death from sepsis, the patient having brought the infection with her from without, and one from cancer of the stomach. Among the last 1,200 he had one death from rupture of the uterus, and one from tuberculosis,, but none at all from sepsis. These observations are evidently of the greatest value and give a broad hint as to what to do and what not to do in cases of labor.

German women are uniformly delivered in the dorsal position, and it seems never to occur to them or their medical attendants to try any other posture. Dr. Mensinga, of Flensburg, in Holstein, calls attention to the following experience: Having occasion to perform podalic version in a woman with a somewhat narrow vagina, he found that by placing her in a prone position, with the thorax and the upper part of the abdomen resting on a pillow, he could very easily grasp the fetal knees, which it had before been quite impossible for him to reach. Version was then easy to perform and the fetus was extracted readily. In fact, Dr. Mensinga says the condition of the perineum up to the anus during the passage of the child's head, can be observed by this method with an accuracy of which he had before had no idea, although, as I may mention, in parenthesis, he is not by any means a young man, but has been engaged a lifetime in gynecological practice.

Dr. Mensinga is the author of some monographs on optional sterility, in which he advocates the insertion of an occlusive pessary of gutta percha into the vagina, where it may remain for any length of time, only being removed during menstruation. Of late years several physicians have directed their attention to this subject, and various methods have been proposed, but to judge from the advertisements of the instrument makers, Mensinga's devise seems to be the one most generally adopted. The question is a highly delicate one, and no doubt has a decidedly immoral aspect, as witness the following case: A young woman had been persuaded by her lover to let him insert one of these pessaries for the purpose of preventing unwelcome results from their illicit intercourse. Some weeks later she began to suffer from urinary trouble, and on admission to the hospital it was found that the pessary had been forced up the urethra into the bladder, where it had become incrusted with concrements, rendering lithotomy necessary. Meanwhile, it is interesting to note, the dreaded conception had not been avoided. Apart from such cases, however, Mensinga shows, in his writings, that there are many married women for whom conception means little short of death, and for such the invention may be of the greatest value. Moralists may object to the whole idea, but when reading these essays, one feels convinced that this is a lesser evil than measures otherwise resorted to, and also than the procreation, perhaps, of mentally and bodily defective issue.

October 5, 1894.

REVIEWS AND NOTICES.

MECHANICAL AIDS IN THE TREATMENT OF CHRONIC FORMS OF DISEASE. By Geo. H. Taylor, M.D., New York: George W. Rodger, pp. 110.

This pamphlet is in five chapters, the first two describing and explaining the action of several mechanical devices for relieving pelvic affections and for developing the chest, or correcting thoracic asymmetry. The rest are concerned with the principles, varieties and adaptations of massage. The first chapter on the mechanical treatment of pelvic affections is very interesting and instructive. In certain forms of disease, the mechanical treatment must be recognized as almost the only rational resource. The marked success attending mechanical treatment, both where privately prescribed and in the various institutions devoted to the subject, should impress practitioners with the importance of knowing its scope and therapeutic value. Dr. Taylor's pamphlet explains the subject scientifically and carefully. It reveals much thought and many new ideas, and well repays the perusal.

A MANUAL OF INSTRUCTION IN THE PRINCIPLES OF PROMPT AID TO THE INJURED, INCLUDING A CHAPTER ON HYGIENE AND THE DRILL REGULATIONS FOR THE HOSPITAL CORPS, U. S. A.; DESIGNED FOR MILITARY AND CIVIL USE. By Alvah H. Doty, M.D., Major and Surgeon Ninth Regiment, N. G. S. N. Y.; late attending Surgeon to Bellevue Hospital Dispensary, New York. Second edition, revised and enlarged. New York: D. Appleton & Co. pp. xvi, 304.

This work is probably the best manual obtainable covering the ground of first aid to the injured. The appearance of a second edition shows that the work is appreciated. It is neatly bound, plainly printed and well and profusely illustrated. Following the lines of the ambulance associations in Glasgow and London, there seems to be an awakening interest in emergency work in the larger cities of this country, and there is certainly an increasing demand among the laity for knowledge of what to do in emergency. In the present work the subject is taken up systematically, giving first an outline of the construction of the human body and the functions of the different organs. Then the description and treatment of the various emergencies are given, and finally, as a matter of considerable interest and importance, the drill regulations for the hospital corps, U. S. Army, are given in full.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held October 2d, the following were granted certificates to practice medicine in this State:

C. F. Burgess, Mendocino City; Cooper Medical College, Cal., Dec. 7, 1893.
Edwin Eugene Endicott, Stockton; Kentucky School of Med., Ky., June 21, 1894.
Antonio R. Gomez, Los Angeles; Central Univ., Madrid, Spain, Sept. 11, 1874.
Nat. Green, Watsonville; Med. Dept. Vanderbilt Univ. Tenn., March 1, 1893.
E. W. Hanlon, Los Angeles; Coll. Phys. and Surg. New York, June 14, 1893.
Marinos P. Hus, Oakland; Univ. of Leyden, Holland, Oct. 28, 1875.
Alfred G. Kelleher, Ukiah; Cooper Med. Col. Cal., Dec. 7, 1893.
William A. Knowles, San Francisco; Med. Coll. of the Pacific, Cal., Nov. 5, 1878.
Orrin T. Maxson, San Diego; Rush Med. Coll. Ill., Feb. 22, 1849.
Joseph A. Miller, San Francisco; Kentucky School of Med., Ky., June 26, 1885.
Francis R. Musser, Oakland; Med. Dept. Univ. Pennsylvania, May 1, 1885.
Marion M. Nichols, Hopland; Med. Dept. Arkansas Ind. Inst. Ark., March 2, 1887. Marion Sims, Med. Coll. Mo., March 20, 1894.
John Henry Ryan, Los Angeles; Bellevue Hosp. Med. Coll. N. Y., March 1, 1872.
August H. Sante, San Francisco; Barnes Med. Coll. Mo., March 20, 1894.
Benjamin O. Webb, Los Angeles; Rush Med. Coll. Ill., Feb. 26, 1878.
Lindley C. Wright, Visalia; Med. Dept. Vanderbilt Univ., Tenn., March 26, 1894.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Div. Pacific), from September 20, to October 21, 1894.

Captain Walter D. McCaw, assistant sugeon, is relieved from temporary duty at the Presidio of San Francisco and will proceed without delay to the Cavalry Camp, Yosemite National Park, and report to the commanding officer for duty until further orders. Par. 2, S. O. 117, Dept. of California, September 24,'94.

First-Lieutenant Charles Willcox, assistant surgeon, and two privates of the hospital corps, to be designated by the post surgeon, Presidio of San Francisco, will accompany Light Batteries D and F, Fifth Artillery, on a practice march from the Presidio of San Francisco to Clear Lake, Cal., on October 4. Par. 1, S. O. 121, Dept. of California, October 2,'94.

Leave of absence for ten days is granted Lieutenant-Colonel J. V. D. Middleton, Deputy Surgeon-General. Par. 1, S. O. 122, Dept. of California, October 4,'94.

Captain William L. Kneedler, assistant surgeon, will stand relieved from performing the duties of attending surgeon in this city, upon the return of Lieutenant Colonel Johnson V. D. Middleton, Deputy Surgeon-General, from the leave of absence granted him in Par. 2, S. O. No 122, C. S. from these headquarters. Thereafter, and until further orders, Lieutenant Colonel Middleton will perform the duties of attending surgeon in addition to his duties as medical director of the department. Par. 6, S. O. 122, Dept. of California, October 4,'94.

Captain William L. Kneedler, assistant surgeon, is detailed as examiner of recruits in this city, in addition to his present duties Par. 7, S. O. 122, Dept. of California, October 4,'94.

The journeys performed by First-Lieutenant E. B. Frick, assistant surgeon, from Fort Townsend to Seattle, Wash., and return, on July 10th, 28th, August 9th, 30th, September 15th and 20th, 1894, on public business in connection with the examination of recruits, in obedience to instructions from these headquarters dated April 5th, 1892, are confirmed. Par. 2, S. O 168, Dept. of the Columbia, October 9,'94.

Leave of absence for twenty days is granted First-Lieutenant Charles E. B. Flagg, assistant surgeon. Par. 1, S. O. 127, Dept. of California, October 15,'94.

The leave of absence for ten days granted Lieutenant-Colonel J. V. D. Middleton, Deputy Surgeon-General, in Par. 2, S. O. No. 122, C. S., from these headquarters, is extended two days. Par. 1, S. O 130, Dept. of California, October 18,94.

Captain Edward C. Carter, assistant surgeon, is relieved from duty at Vancouver Barracks, Washington, and ordered to Fort Buford, South Dakota, for duty, relieving Captain Aaron H. Appel, assistant surgeon.

First-Lieutenant Benjamin Brooke, assistant surgeon, is relieved from duty at Camp Pilot, Butte, Wyoming, and ordered to Fort Canby, Washington, for duty.

First-Lieutenant Thomas N. Raymond, assistant surgeon, is relieved from duty at Fort Canby, Washington, and ordered to Fort Riley, Kansas, for duty.

Captain John L. Phillips, assistant surgeon, ordered to report in person to commanding officer Fort Walla Walla, Washington, for duty at that station, the assignment to duty at Fort McKinney, Wyoming, being revoked.

Major M. W. Wood, surgeon, on being relieved from duty at Boston, Massachusetts, will proceed to take station at Boise Barracks, Idaho, to relieve Captain William Stephenson, assistant surgeon. Captain Stephenson, on being relieved, will proceed to take station at Vancouver Barracks, Washington.

Upon abandonment of Fort Marcy, N. M., Major James P. Kimball, surgeon, is ordered to Fort Wingate, N. M , for duty.

Upon the arrival of Major Kimball at Fort Wingate, Captain C. N. B. McCauley, assistant surgeon, will take station at Fort Apache, Arizona, for duty, relieving Lieutenant M. W. Ireland, assistant surgeon.

Lieutenant Ireland, on being thus relieved, will take station at Fort Stanton, N. M., relieving First Lieutenant F. R. Keefer, assistant surgeon.

Upon abandonment of Mount Vernon Barracks, Alabama, Major Curtis E. Mann, surgeon, is ordered to Benicia Barracks, Cal., relieving Captain Ogden Rafferty, assistant surgeon.

Captain Rafferty, on being relieved by Major Mann, is ordered to Presidio of San Francisco, Cal., for duty.

First-Lieutenant Charles E. B. Flagg, assistant surgeon, is relieved from duty at Presidio of San Francisco, Cal., and ordered to Angel Island, Cal., for duty.

Major Van Buren Hubbard, surgeon, is relieved from duty at Fort Spokane, Washington, and ordered to Fort McPherson, Ga., for duty at that station.

Upon abandonment of Fort Bowie, Arizona, Captain Jefferson D. Poindexter, assistant surgeon, is ordered to Fort Riley, Kansas, for duty.

ITEMS.

Dr. A. Abrams, of San Francisco, who has been spending several months in Europe, expects to reach home November 25th, when he will resume his practice.

Occidental Medical Times.

Vol. VIII. DECEMBER, 1894. No. 12.

A CASE OF PROTOZOIC SKIN DISEASE.

By W. S. Thorne, M.D., San Francisco, Cal.

Read before the California Academy of Medicine.

T. P——, Portugese, æt. 33; occupation, laborer and saloon-keeper; has lived in California fourteen years, was in his usual health up to June 1st, when he had a hemorrhage that from his description was evidently hemetemesis; he thinks he lost about a half-pint of blood. At this time his only sense of discomfort was that of weakness. About five weeks after the hemorrhage, he observed a change in the color of his urine, which looked to him like blood, and it was at this time also that he first noticed two reddish spots on his forehead, left arm and breast. The eruption was attended with pain.

His condition on entering St. Mary's Hospital, August 28th, was as follows: A tall, thin man—evidently much under weight—the palor of whose face is in marked contrast with his dark eyes and hair. An eruption upon the head, face, chest and arms—number, fifteen in all. Two (the least advanced of these) appear near the base of the right ala of the nose. It begins as a small pimple with a red indurated base. The four growths upon the forehead and scalp are as large as a five-cent silver piece, and have already passed into the suppurative stage; thin margins are elevated above the skin a fourth of an inch, and the summit presents the color and appearance of a raspberry.

Under observation, the area of redness and induration extends; the summit softens and breaks down; about the base small pustules appear, which in turn break down; the surface of the sore, from a condition of elevation becomes cupped and excavated, with the margins ragged and irregular, attaining a size of two centimeters in length, by one and three-quarters in breadth.

This patient has never had syphilis or rheumatism. There are no hereditary disorders in the family history. During the period of our observation of him, the daily range of temperature has been from 100° F. morning to 103° evening, pulse from 100 to 125. The cervical glands of both sides are moderately swollen, as well as the glands of the groin. The urine is scanty, but otherwise normal; on first examination it was found to contain blood, but disappeared in a few days.

I had promised to present this patient to the Society this evening for personal inspection, but regret to say that he is so feeble that I am not able to do so. In the early part of the week, I invited Dr. Rixford to examine the patient with me, and at his suggestion, I excised a mature sore situated over the right clavicle, for microscopical examination. Dr. Rixford has had the kindness to prepare this specimen for your examination, and he has consented to be here to-night to give you his views of the pathology of the case.

813 Sutter street.

A CASE OF PROTOZOIC DERMATITIS.

Read before the California Academy of Medicine.

By EMMET RIXFORD, M.D., San Francisco, Cal., Adjunct to the Chair of Surgery, Cooper Medical College.

I wish to express my thanks to Dr. W. S. Thorne and Dr. Luke Robinson, to whom I am indebted for the privilege of studying this most interesting case of skin disease, whose clinical history you have just heard, and for the opportunity of making a report of its pathology.

The case is identical with one now in the City and County Hospital, which was exhibited at the March meeting of the San Francisco Medico-Chirurgical Society, a brief account of which is published in the May number of the OCCIDENTAL MEDICAL TIMES of this year, in the minutes of that meeting. The complete history and pathological study of the case will shortly appear in the Johns Hopkins Hospital Reports.

These two cases are particularly important from a pathological standpoint, in that they present skin lesions containing *bodies which are demonstrably protozoa.* This condition must be extremely rare, for the literature contains only one similar case, I am told, which is reported by Wernicke, of Montevideo.

The lesion is essentially a group of hypertrophied papillæ, bathed in pus. The patches vary in size, the largest in this case being about one by two inches in diameter, while the individual papillæ are perhaps one-twentieth of an inch in diameter. The edges are elevated, congested, and slightly undermined. Gentle pressure on the patch causes more or less pus to exude from between the papillæ. This secretion, which is rather abundant, dries on the surface, forming a dirty crust, which, however, is easily removed. The lesion is evidently confined to the skin, for it is freely movable over the subcutaneous tissues.

The pus is filled with great numbers of protozoa, similar to those found in the first case; these are organisms spherical in form, having a highly refractive capsule, within which is contained a mass of irregularly granular matter. In the older individuals, this central matter arranges itself into definite points or spheres, which are, without doubt, spores. At a later stage, the capsule ruptures, setting the spores free. Many intermediate forms are found between the newly-freed spores and the mature form; and then, too, there are to be seen numerous capsules which have ruptured. The organism in all stages, from the most minute form to the full-grown adult, present a capsule, excepting only the newly-freed spore.

Microscopical preparations of a patch which was excised from the case in the City and County Hospital show an atypical growth of epithelium, with prolongations of the inter-papillary processes into the sub-mucous connective tissue; numerous miliary abscesses in the thickened epithelium, the source of the pus, and peculiar collections of cells in the connective tissue of the corium, resembling miliary tubercles. These last consist of epitheloid cells, surrounding one or more giant cells, such as are seen in tuberculosis, *i. e.*, with peripherally distributed nuclei. In the interior of each giant cell, or in its immediate vicinity, there are found one or more protozoa, a few spores or a dead capsule. In the tissue from Dr. Thorne's case, the protozoa are much more numerous than in the other; a larger proportion of them are in the stage of sporulation, which, perhaps, accounts for the more rapid progress of the disease. In the few sections examined, no giant cells were seen—a fact which may be due to the short duration of the disease—just as in tuberculosis, where giant cells are most numerous in the chronic cases, *i. e.*, in fibrous tubercles. However, the atypical growth of epithelium is present with the numerous miliary abscesses containing the organisms.

The protozoa in the second case differ slightly from those found in the first, viz.: in being somewhat larger, in taking nuclear stains more readily and in presenting a large vacuole in the center in some forms.

The disease is accompanied with considerable pain and exquisite tenderness, as one would expect from the fact that the condition is a severe dermatitis, with little necrosis of tissue, so that the cutaneous nerve filaments remain to be subjected to severe irritation. It is terribly destructive; in the case in the County Hospital, it has invaded both orbits, destroying both eyes; it has destroyed the soft parts of the nose, half of one ear and much of the upper lip. It has entered the mouth and attacked the gums.

The condition has shown itself to be particularly rebellious to treatment. In the case at the County Hospital, a great variety of local applications were tried: bichloride of mercury, iodine, bromine, carbolic acid, methyl violet, turpentine, etc., were applied externally on lint and injected into the base of the lesions, all with practically no effect. Since the tissue of the lesion is soft and friable, it was thought the curette would remove the greater part of the disease and permit better access of the antiseptics to the deeper layers. The patches were thoroughly curetted and the raw surfaces scrubbed with a 1:500 bichloride of mercury solution. This treatment was effective wherever it could be applied. The resulting cicatrix is soft and pliable and shows no tendency to contract. The largest patch so treated was that on the back of the neck which was about six by eight inches in extent. It is now thoroughly healed. Some of the patches were excised *in toto* and the wounds closed by suture. These healed in most cases without reinfection.

The disease is distinct from Darier's Psorospermose Folliculaire Vegetante, in that it has no relation with the sebaceous glands which are primarily the seat of the latter affection, and it presents no sebaceous horns. Among other distinguishing features it should be mentioned that the organisms here are readily shown to multiply by sporulation, while this has not been made out satisfactorily in Darier's cases. In fact, grave doubt has been thrown on Darier's bodies being protozoa at all.

While the lesion under the microscope presents groups of cells greatly resembling miliary tubercles, the disease is probably not a tuberculosis in which the protozoa are an accidental complication. The uniformity with which the giant cells contain the protozoa, the fact that many sections were stained for the tubercle bacilli without their being found, and the fact that inoculation of rabbits with the protozoa-bearing tissue (animals which have almost no resistant power against tuberculosis) has in some cases produced chronic sores containing the protozoa and never a miliary tuberculosis, excludes all probability of this disease being tubercular.

The occurrence of this second case with lesions clinically and microscopically identical with the first, and the finding of protozoa in it differing but slightly from those of the first case, greatly strengthens the probability that the protozoa are the essential causative factor in the disease.

Dr. Thorne's patient was a native of the Azores Islands, but had resided here fourteen years; my patient was also a native of the Azores and had lived here seven years. Both were previously healthy and worked in the San Joaquin valley for some time before the trouble began. My patient had also worked about the docks in Port Costa and San Francisco, in unloading ships, many of which came from the tropics. It was thought possible that the infection was acquired in the hold of one of these vessels. However, since two cases have occured here, both hailing from the San Joaquin valley, it may be that the origin of the infection is nearer home.

If this be true, there must be more cases in California, and I take this opportunity to suggest that if any of the readers of this paper have cases resembling tuberculosis of the skin or mycosis fungoides, *i. e.*, with lesions elevated and consisting of hypertrophied papillæ, and secreting considerable quantities of pus, that they put a drop of the pus under the microscope and search for spherical organisms such as are described above. They are well seen with an ordinary one-fifth inch objective and two inch ocular. I should esteem it a favor if any similar cases should be reported to me, and in doubtful cases I should gladly make such microscopical examination.

If so destructive a disease is to become common in California (my case, it will be remembered, lost both eyes, his nose, and part of an ear, and Dr. Thorne's case died[1]), it is important that the subject receive exhaustive study. From the limited observations thus far made, the only treatment that bids fair to be of permanent benefit, is early excision or complete erasion.

313 Ellis street,

STATISTICS OF MORTALITY FROM ANESTHESIA.

Read before the San Francisco Medico-Chirurgical Society.

By L. C. LANE, M.D., San Francisco, Cal.

Deaths from the administration of anesthetic agents occasionally occur, and will continue to do so, in spite of the greatest caution in their use; how great the chance of death from such agency is can only be learned from the reports of careful statisticians on this subject.

In 1880, in a work published by Dr. O. Kappeler, of Thurgan, Switzerland, on anesthetics, one finds the following figures:

In America, Dr. Andrews finds that in 117,078 cases of chloroform narcosis, there occurred 43 deaths; that is, 1 in 2,723 administrations.

Dr. Coles, in a paper read before a medical society of Virginia, gave the following report:

Ether	4 deaths in 92,815 cases.
Chloroform	53 deaths in 152,260 cases.
Ether and chloroform mixed	2 deaths in 11,176 cases.

Richardson, of England, collected 11 deaths in 35,165 administrations of chloroform.

In Edinburgh, Kerr finds 1 death in 36,500 administrations of chloroform.

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[1] The patient died of exhaustion a few days subsequent to the reading of this report. No autopsy was permitted.

In a report of the war of the rebellion in America, there were 7 deaths in 80,000 administrations of chloroform.

Nussbaum, of Munich, reports that he had no death in 15,000 administrations of chloroform.

Kappeler states that when he was assistant surgeon to the hospital of Zurich, there occurred but 1 death in 5,000 cases of inhalation of chloroform.

The several reports given vary so greatly, that it is difficult to deduce a proper average from them; though some of the reporters endeavored to do so, yet their figures are not trustworthy.

In the 48th volume of the *Archiv. für klinische Chirurgie*, E. Gurlt, of Berlin, the famous statistician, has published the result of his studies, and which, as the most reliable work, probably, done in this field, I herewith present in summarized form:

Of 166,812 administrations of chloroform, in the period from 1889 to 1894, there occurred 63 deaths; on an average 1 in 2,647 administrations.

During the same period, among 26,320 patients anesthetized by ether, 2 died; that is, 1 in 13,160.

From a mixture of ether and chloroform, there occurred but 1 death in 8,014 administrations.

From a mixture of alcohol, chloroform and ether, known as "Billroth's mixture," there occured 1 death in 4,190 administrations.

From bromide of ethyl, there occurred 2 deaths in 7,541 administrations.

Some years ago, Dr. Squibb stated that the deaths from anesthetics would probably be more accurately represented if the published cases were doubled, so as to represent the unpublished ones.

From recent experimentation it has been determined that in death from chloroform the heart continues to act for a time after breathing ceases.

Artificial respiration, in which the chest is caused to alternately expand and contract, is the usual method resorted to for resuscitating the patient in whom death seems impending from an anesthetic.

Kraske, in 1892, modified the Silvester method in this, that after five breaths, he closes the nose and mouth, and makes the inspiratory movement.

As additional aid, König has advised to make rapid pressure over the heart; such pressure should be repeated 120 times a minute.

652 Mission street.

CHRONIC INTERSTITIAL NEPHRITIS

By J. ELLIS RODLEY, M.D., Chico, Cal.

Read before the California Northern District Medical Society.

I desire to call attention to that form of Bright's disease, which is designated by the several synonyms, chronic interstitial nephritis, cirrhotic kidney, granular contracted kidney and gouty kidney; names which have reference to the pathological process characterizing the affection, to the anatomical change to be observed after death, and to the frequent association with a special diathesis, or constitutional state.

These anatomical changes and *post-mortem* appearances, both to the eye and to the microscope, are sufficiently familiar to render it unnecessary to rehearse them. It is to the clinical features of the disease, to the many and varied signs and symptoms which develop during its long and tedious course, that I would ask your attention. Of all the varieties of Bright's disease, this is the most gradual in its developments, the most prolonged in duration, and yet the most intractable and fatal.

My own experience has led me to believe that many persons suffering from this form of disease are treated for one of the complications which appear during its progress, and which, often excite no suspicion of the real nature of the complaint. It is not through ignorance, or even a want of familiarity with this disease, that it escapes detection in the early stages, but rather through incompleteness, and carelessness of investigation. The symptoms are so simple, so easy of explanation, that the inquiry of the physician is soon arrested, leaving the real disease to be discovered by a more thorough diagnostician. Stomach disturbances, nervous derangements, neuralgias, irregularities of the heart's action, painful and distressing lung affections, as asthma, are wrongfully diagnosed and treated as diseases, when they are really symptoms of a graver affection.

I feel satisfied that most of the subjects of this disease have been affected for some time before their condition is understood, simply because their complaints have been so trifling in their immediate effects upon their general health as to cause no anxiety. In other cases the patient has never sought medical advice, supposing himself to be in good health, until some urgent or distressing symptom causes him to seek relief.

Some years ago I was requested to see a gentleman, who, for some time, had been under treatment for "chronic pneumonia," which had resisted all medication; patient said that previous to this attack he enjoyed excellent health. Physical examination of the lungs showed dulness on percussion over both bases, posteriorly. Auscultation revealed fine crepitant rales; there was cough with white frothy expectoration, and moderate dyspnea. These signs and symptoms, of course, indicated edema of lungs. The heart was enlarged, and auscultation revealed endocardial and exocardial murmurs. Urine specific gravity, 1014; albumin and granular and hyaline casts; there was no visible edema, with the exception of a slight puffiness of the lower lids. A thorough inquiry into the history of this case, revealed the fact that, although active, both mentally and physically, he had been a sufferer from digestive derangements, and at times shortness of breath on climbing or walking up hill.

By appropriate treatment the lungs were relieved, and the patient improved considerably. An unfavorable prognosis was doubtfully accepted by the family, who sought further opinion and advice, but the patient eventually returned to my care, and died 18 months after I first saw him. A few weeks before death, considerable dropsy of the lower extremities developed, and he suffered most distressingly from dyspnea.

This patient was regular in all his habits of life, and yet, notwithstanding his avoidance of excess, he had been a sufferer from dyspepsia, which, in the absence of other causes, must claim consideration as being a factor in the production of the disease.

Three years ago, Mr. D——, a large and healthy looking man called at my office to consult me. As he walked across the room, I noticed that there was more shortness of breath than ought to have been caused by walking up the stairs. He informed me that he had a cough with white, frothy expetcoration, and that Dr. —— had told him he had bronchitis, but had done him no good. Physical examination of the chest showed dulness over both lungs, posteriorly. There was hypertrophy of the heart; the urine contained albumin and granular and hyaline casts. There was no dropsical effusion, except in the lung. The patient always considered himself to be in good health, and although he indulged freely in liquors had never before been seriously ill. He was very much distressed at my diagnosis and prognosis, and went to San Francisco where he was treated for bronchitis, asthma and stomach trouble. He finally returned to me, having meanwhile developed a moderate amount of dropsy, with considerable difficulty of breathing. He rapidly grew worse, and medication seemed to give little relief; the dropsy gradually increased, and he died in a short time from uremic poisoning. In these two cases no suspicion of the real disease was excited and no urinary analysis had been made, because of the incorrect diagnosis of lung complication.

About eighteen months ago, I was called to the Park Hotel to see a gentleman, about 50 years of age, who had come from Buffalo, N. Y., with a party of friends, on a pleasure tour of this State. He was taken suddenly ill shortly after his arrival at Chico. I found him suffering intensely from orthopnea, and physical examination revealed considerable edema of both lungs. The urine contained albumin and hyaline and granular casts. The heart was hypertrophied, pulse quick and of high tension. No dropsical effusion was manifest, except in the lungs. Patient claimed to have always enjoyed good health up to this time. Jaborandi was given with good effect; the dyspnea was relieved, and in a few days he was enabled to resume his journey homeward.

It is not infrequent for just such accidents as this to first draw the attention of patient and physician to a serious organic lesion in an individual of apparently good health, or who had, at least, no complaint compelling him to seek professional advice. It would seem that in such cases the changes in the kidney have not advanced so far as to destroy its activity, but that in its crippled condition, with sudden exposures to cold or to climatic changes, the function of the skin is interfered with, and disturbance in the circulation of the kidney occurs. The altered state of its blood supply favors and maintains congestion, so that its function is decreased, and rapid effusion into that part whose structure offers the least resistance. Therefore, the lung is most apt to suffer in these attacks.

The case of G. S—— furnishes a fair illustration of this type. He was engaged in the livery business, part of his duties consisting in going to meet an early morning train. After these trips, on a cold morning, he was attacked with dyspnea and vertigo. His physician diagnosed asthma, and for 15 months he was under treatment for that disease, being unable to lie down at night, but taking what rest he got in a chair. Notwithstanding, all this time he was actively engaged in business, till one morning he was so much worse that his physician honestly declared he did not know what was the matter. Under these circumstances I was sent for. I found the patient suffering from the most intense dyspnea, the face anxious, and the pulse tense and bounding. Physical examination revealed dulness over both lungs, posteriorly. Urinary analysis showed albumin and casts in abundance. There was slight anasarca in the ankles, with puffiness of the eyelids.

The diagnosis necessarily led to an unfavorable prognosis, which the family received very reluctantly. Dr. Stansbury, who saw him with me at this time, fully concurred in the diagnosis. Under appropriate treatment, the edema disappeared; he was enabled once more to sleep in the recumbent position, the cough ceased, and for some time he enjoyed very fair health. About this time he took a long and arduous trip to the mountains, which, from the cold and exposure, necessarily brought about a return of the edema of the lungs. He returned in a desperate condition, suffering intensely from dyspnea, which soon assumed the form of Cheyne-Stokes respiration, and continued, more or less constantly, up to the time of his death. During the last few weeks, a high degree of edema of the lower extremities, involving the thighs and scrotum, also developed.

The most constant feature in the subjects of contracted kidney is the absence of visible dropsy in the earlier stages. It is important to lay stress upon this point, since it is to this feature that may be due the oversights in the recognition of the disease. I am inclined to believe that among the many causes to account for the production of disease none is more frequent than long, persistent dyspepsia. The frequent repetition of over indulgence at table, either eating or drinking, results in gastric discomfort and subsequent derangement of the urinary apparatus, which in time must beget an irritation of the cellular elements of the kidney; the nutrition of these cells, through deranged circulation, is impaired, and the first step toward slow chronic inflammation, involving the connective tissue and causing desquamation of the epithelium of the uriniferous tubules, takes place. If the urine be examined at this time, it may be free from albumin, but the microscope will reveal epithelium from the tubules of the kidney.

The same condition exists after the administration of diuretics, which are known to cause irritation of the kidney, such as cantharides, turpentine and balsam of copaiba. Gonorrhea may therefore be classed as an indirect cause of chronic nephritis, not through extension of the gonorrheal inflammation, but through the influence upon the kidney of the remedies administered. If the irritation be continued from any cause, the delicate basement membrane of the tubules being denuded of its epithelium, is thus directly exposed to the action of the irritating agent; the supply of blood is increased in the adjacent blood vessels, transudation takes place into the uriniferous tubules, and we find uriniferous casts and epithelium in the urine. Increased blood supply and escape of new germinating material into the connective tissue stimulates it to activity, and so we have proliferation of its cellular elements and growth of the tissue itself. This new tissue undergoes contraction and obliterates the malpighian tufts and tubules of the kidney.

The lesson to be learned from this theory of the disease and the operation of its causes is, that attention should be given to all cases of persistent dyspepsia, bearing in mind not only the effect upon the stomach and intestine, but the remote and lasting derangement of the kidneys, upon the action of which so much depends. The frequent use of the microscope in all cases of aggravated dyspnea furnishes a safeguard against error and an early warning of the beginning of mischief.

THERAPEUTICS A SCIENCE OF PRECISION.

By E. J. Boyes, M.D., C.M., Oakland, Cal.

It were trite to say that the field of medicine is thronged with countless drugs and drug compounds. The fact is in bewildering daily evidence. Of these, some are good, others indifferent, and many vicious, in their exhibition as therapeutic agents. Moreover, this overwhelming swarm of medications is impossible in another respect than the numerical. I refer to the disturbing variety in potency and in form, in which they appear in our hands for exhibition.

To a man entering upon the practice of medicine, it must be appalling, since so many of us, after years of practice, during which we have crystallized our materia medica diligently, feel somewhat dizzy when we try to appreciate the remedial measures of to-day. Surely, never in the history of medicine were there such multitudinous preparations, and humbly we trust it may be otherwise soon. It would appear that nature had been exhausted to contribute, and still they come, bringing with them discouraging confusion of opinion as to the merit of each. As if to add to the difficulties of recognizing these hordes, and striving to cultivate a fair acquaintance with a sufficient number in their ranks to constitute an armamentarium for actual warfare in daily practice; as if to make confusion worse confounded, I repeat, we are called upon to estimate the virtues of each, in form of tincture, infusion, fluid extract, emulsion, normal liquid, cordial, elixir, essence, pill, capsule, tablet, etc., *ad nauseam.* Briefly, we find ourselves (or are lost, rather,) in the midst of a vast assemblage, whose members take on a variety of disguises.

You will all admit the truth of these premises. They do not originate with me, but are the puzzled wail of thousands in our ranks. But now for the remedy. We are all agreed as to the evil. Is there any way out? How shall we proceed? Can any one man hope, from day to day, from year to year, to work and at the same time enter into elaborate research regarding every drug in each form in which it is manufactured to-day? Failing in that, is it wise to be content with our old knowledge and to ignore innovation and progress, and thus be without many splendid, new, keen weapons of modern medicine? Certainly, no one would seriously advocate either of these extremes; and yet the profession is strung all the way along the line between the two positions.

But there is one alternative. There is a method of therapeutics now coming into use that is relatively as clear and definite as the science of surgery, and keeps pace with progress in pathology and physiology. Its development and perfection will, as the years go by, redeem medicine from empiricism and establish therapeutics as a science of precision.

I refer to the use of active principles, singly and in intelligent combination. Who would think of using opium when he desires the physiological effects of codeine, or the results to be got from morphine, or the selective action of apomorphine? Or who would prefer the crude, bulky drugs from which we obtain quinine, strychnine, or atropine? Then, why should any one exhibit digitalis in tincture or fluid extract, *et al.*, thereby giving his patient the dubious benefit of digitalium and digitoxin, as well as the digitalin, the desired principle? It is obvious what the verdict must be. And so we might go over a long list of potent medicines, and would find it possible to get corn, removed from the cob, and the husk thrown away.

What is true of morphine and quinine is as true of aconitine, and hyoscyamine, and pilocarpine, and gelsemminine, etc. In short, I claim it is evident that there is one intelligent and scientific pharmacology, and one only, and that is alkaloidal in principle. Moreover, now that the system is so complete, I am amazed that a larger part of the profession has as yet failed to take advantage of it.

Clay and Thirteenth streets.

A CASE OF NORMAL PREGNANCY IN A WOMAN WITH ONLY A PORTION OF ONE OVARY.

By B. Sherwood-Dunn, M.D. (Paris), Paris, France.

A California surgeon lately on a visit to Paris, expressed some doubt as to the possibility of pregnancy in a woman possessed of only the part of one ovary, and having observed this occur, after operations similar to the following, in several cases, I promised to report in the Occidental Medical Times the first instance that should present itself in our hospital service.

The opportunity has arrived sooner than I could have expected. The patient, a woman of 36 years, came to Broca Hospital the 12th of September, in the second stage of labor at term, and two hours later was delivered of a female child, weighing 6 pounds and 12 ounces. The child was well formed and strong, and left the hospital with its mother eleven days later. The hospital matron called my attention to the case as being one of our former operations that I wished to note, and it proves to be very interesting.

This woman is the mother of five children. Her confinements were uncomplicated and free from subsequent accident until the birth of the fourth child. Some time after this the region of the left uterine appendages became extremely painful and sensitive, accompanied by an abundant leucorrheal discharge. The pain gradually increased until by crisis she several times lost consciousness. For two years she frequented different clinics, being treated by injections, intrauterine applications, cervical cauterization and glycerin tampons. She entered Broca Hospital in October, 1892, for examination, and when told that nothing but an operation could relieve her, she left, but returned January 18, 1893. Between the dates of her departure and return she suffered constantly, being confined to her bed the greater part of the time.

The hospital record shows she was operated upon February 10, 1893, by Professor Pozzi. Examined under chloroform immediately preceding the operation, the vaginal walls were found relaxed, permitting the uterus to fall somewhat. Through the left lateral vaginal *cul-de-sac* a hard, corrugated tumor was felt (parenchymatous salpingitis) with probable thickening of the appendages. Through the right lateral *cul-de-sac* the uterine appendages were made out with difficulty, and found to be little, if any, increased in volume. The lesions discovered were determined to be of long standing (perimetritis, perisalpingitis, etc.).

Laparotomy was performed. The left ovary brought through the opening was found to be friable, with irregular protuberances of fibrous character and numerous sanguineous cysts (sclero-cystic degeneration). The fallopian tube was thickened, its extremity livid and extrophiated, but permeable. Despite this fact it was thought best to remove it with the ovary. The right ovary brought into view, presented a tumor at its external border of the size of two peas (cyst of the corpus-luteum). The remainder of this ovary appeared healthy. The fallopian tube was thickened and congested. Passing a stilet through its lumen proved it to be unobstructed, and it was decided to excise the small ovarian tumor, which was done by resecting at this point about one-quarter of the body of the ovary. The borders of the wound thus made were brought together and sutured with fine catgut. The slight hemorrhage resulting was arrested by aid of the thermo-cautery. The ovary and tube were returned to the abdominal cavity and the abdominal incision closed.

The patient recovered rapidly and left the hospital on March 12, and we did not see her again until her entry for her present confinement. I learned in interrogating the woman that since the operation she has been free from pain, improved in general health and condition and commenced menstruating three months after the operation.

15 rue des Pyramides.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and

HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Oxalic Acid as an Emmenagogue.—The emmenagogic effects of oxalic acid, given in doses amounting to 2 grammes a day, are very marked, but its disagreeable taste is a disadvantage. It may be made more acceptable if put up according to the following formula:

Oxalic acid	gm. 2
Neutral glycerin	gm. 40
Orange flower syrup	gm. 60
Water	gm. 400

One-quarter of a glass every hour.—*Gazette de Gynécologie*, August 15, 1894.

Treatment of Diphtheria by Sero-Therapy.—Animals may be rendered refractory to diphtheritic inoculation by the injection of increasing doses of the soluble products of the Leoffler bacillus cultures, and the blood serum of these animals injected into other animals of the same or of different species, exercises a similar protective influence. When this germ is injected into subjects already inoculated with toxic products, it acts as an antidote to those products, while rendering the organism refractory to future inoculation. Horses are preferable for these experiments, because they furnish serum of a high antitoxic quality, and they are capable of affording large quantities without injury to their own health. This method of securing immunity from diphtheritic poison was introduced by BEHRING and his collaborators, and it has been applied to the treatment of children suffering from diphtheria with most encouraging results. At the Children's Hospital, in Paris, during the four years from 1890 to 1893 inclusive, there were 2,029 deaths in 3,971 cases, or 51.71 per cent. At the same hospital, during the first six months of the present year, M. BRUX, of the Pasteur Institute, inoculated 448 children suffering from diphtheria, with serum obtained from a horse previously rendered refractory to this disease. The percentage of deaths was 24.5 per cent., or in round numbers, one-half as great as before. This result is the more valuable because all the other conditions of treatment remained exactly the same. Among 520 cases treated at the Hospital Trousseau during this time, the mortality reached 60 per cent. The figures furnished by M. Brux are taken *en bloc* and include the severest forms of diphtheria, as well as those cases—on the average 1 in 4 in the diphtheria ward of every hospital—in which sore throat is accompanied by false membrane, but is free from diphtheria bacilli. Analysis of these figures show that while the serum injections were of evident benefit in all kinds of diphtheria, the best results were obtained in the class of pure diphtheria, in which the mortality was only 75 per cent. Local and general improvement was almost immediate in cases of pure diphtheria, treated from the beginning by sero-therapy. False membrane was easily removed, and, after a few days, ceased to appear. The larynx was more rarely invaded, croup was cured without surgical intervention, and secondary accidents were of less frequent occurrence. DR. ARONSON, a German, who has treated 169 cases according to this method, reports a mortality of only 11 per cent. M. Brux is so enthusiastic concerning sero-therapy that he thinks no local treatment necessary except washes of boracic acid solution. This is going too far. It is safer to combat such an enemy with two weapons than one. The removal of a mass of microbes, thus preventing the spread of their toxic products through the system, must be beneficial. We must take care, however, to avoid excoriation of the mucous membrane, or we may add therapeutic poisoning to the poisoning already existing.—*Gazette des Hôpiteau*, September 25, 1894.

SURGERY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal., and

G. F. SHIELS, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco.

Appendicitis Obliterans.—In a paper on this subject (*Journal American Medical Association*) SENN formulates the following conclusions: (1) Appendicitis obliterans is a comparatively frequent form of relapsing inflammation of the appendix vermiformis. (2) It is characterized by progressive obliteration of the lumen of the appendix, by the gradual disappearance of the epithelial lining and glandular tissue, and the production of granulation tissue from the submucous connective tissue, which, by transformation into connective tissue and cicatricial contraction, starves out remnants of glandular tissue, and finally results in obliteration. (3) The obliterating process manifests a progressive tendency, and may finally result in a complete destruction of all glandular tissue and obliteration of the entire lumen. (4) The incipient pathological changes occur either in the mucous membrane of the appendix, in the form of superficial ulceration, or as an interstitial process following lymphatic infection. (5) The most constant symptoms which attend this form of appendicitis are relapsing acute exacerbations of short duration, moderate or no appreciable swelling at the seat of disease, and persistence of soreness and tenderness in the region of the appendix during the intermissions. (6) The process of obliteration may begin at the distal or proximal end, or at any place between, or it may commence simultaneously, or in succession at different points. (7) Obliteration on the proximal side gives rise to retention of septic material, which finds an outlet through the lymphatics, giving rise to non-suppurative lymphangitis and lymphadenitis. (8) Circumscribed plastic peritonitis is an almost constant concomitant of appendicitis obliterans, and hastens the process of obliteration. (9) Complete obliteration of the lumen of the appendix results in a spontaneous and permanent cure. (10) In view of the prolonged suffering incident to a spontaneous cure by progressive obliteration and the possible dangers attending it, a radical operation is indicated, and should be resorted to as soon as a positive diagnosis can be made.—*Therapeutic Gazette*, September, 1893.

Aseptic and Septic Surgical Cases with Special Reference to the Disinfection of Skin, Sponges, and Towels.—LOCKWOOD, in a paper upon this subject (*British Medical Journal*), says: The difficulty of rendering the skin sterile, as has been so often remarked upon, is emphasized by his present investigations. In a number of operations the skin was disinfected with the greatest care, after the most approved modern methods, including vigorous scrubbing with soap and warm water, followed by carbolic lotion 1:20, bichloride lotion 1:1000 and 1:500, solution of potassium permanganate and solution of oxalic acid; notwithstanding, small portions of skin dropped into culture-tubes invariably resulted in the growth of one or more of the various bacteria which infect the skin. Some of the operation wounds, however, ran a sterile course. The comparative inefficiency of corrosive sublimate and carbolic acid to inhibit bacterial growth was demonstrated by mixing solutions of these chemicals, in different proportions, with broth cultures, and it was found that inoculated colonies continued to grow in these media. The failure of watery solutions to penetrate the pores of the skin has been recognized for some time, and an effort made to overcome this defect in the *technique* by employing alcohol, ether, or benzine. In view of this fact the author was induced to employ glycerin as a vehicle for applying the chemical antiseptic. Accordingly bichloride in glycerin 1:2000, and carbolic acid in glycerin 1:40, were applied after the usual preparation of the skin, 24 hours before operation. This plan was more successful. In about half of the cases test-tubes inoculated with fragments of skin so prepared remained sterile. Inasmuch as biniodide of mercury is not precipitated by albumin, it was thought that this substance might yield more satisfactory results. Of two trials, however, the skin was found by culture-experiments to have been aseptic in one and to contain staphylococcus albus in the other. Of 21 experiments upon the disinfection of the skin which have been carefully detailed, 7 were successful—in 6 the wounds healed by first intention, without either local or constitutional reaction. In 14 of the cases the skin was septic—9 of these healed by first intention and 5 suppurated. In none of these, however, was the suppuration severe or prolonged. In regard to disinfection of the hands, the author states, the best results have followed the usual thorough scrubbing with soap, hot water, and nail-brush, cleansing the nails and then immersing for one minute in a 1:1000 solution of sublimate in alcohol. The observation on the disinfection of towels is interesting: Three of four towels which had been soaked for two hours in 1:20 carbolic solution were found to contain staphylococcus pyogenes albus. In another case a towel which had been kept in carbolic solution 1:20 for 24 hours grew a bacillus. In another case a towel which had been immersed for 24 hours in a solution of the same material was sterile. The result of the use of bichloride was also not uniform. Of 6 experiments in sterilizing towels by the steam sterilizer for a half-hour, 5 were successful and 1 failed. The latter was attributed to the towel having been tightly folded during the sterilizing process. By taking the precaution of placing the towel loosely in the sterilizer, the author believes this this method may be relied upon; the towels being kept, of course, in antiseptic solutions after being taken from the sterilizer. The sponges were prepared as follows: If new they were well shaken, then soaked in a solution of hydrochloric acid (1 drachm to a pint) for 24 hours. Next they were thoroughly washed and squeezed out in water at the temperature of 100° F.; and then immersed in a cold solution of sulphurous acid (1:5) for 12 hours, being kept below the surface of the water. Lastly, they are squeezed as dry as possible and placed in carbolic solution 1:20, ready for operation. Of 12 experiments with sponges so treated, 11 were found to be sterile, the failure having occurred when the process was carried out by an experienced person. As carbolic acid evaporates rapidly, the jars containing the sponges must be tightly stoppered. These experiments show that asepsis is with the greatest difficulty obtained by the use of chemicals, but once secured, either by this means or by heat, dilute solutions of chemicals suffice for its continuance.—*American Journal of Medical Sciences*, August, 1894.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

A Case of Laryngectomy by a Novel Method.—DR. H. L. SWAIN reports the case of a laryngeal epithelioma removed by a new method, A sponge Trendelenburg canula was introduced into the trachea. The skin was incised from the sternum to the hyoid bone, with a cross cut to the sterno-cleido mastoid. The larynx was carefully laid bare and bleeding checked. When all was cleared away, a director was carefully passed back of the trachea, between it and the esophagus, and the larynx severed from the trachea. The larynx was carefully dissected away from the anterior wall of the esophagus, from below, upward. When the arytenoid cartilages were reached, the direction of the incision was changed and directed toward the base of the epiglottis, including in its path the mucous membrane covering the arytenoids and portions of the ary-epiglottic folds. The epiglottis was cut through the tuberculum, and the larynx soon freed from all attachments. The epiglottis was then stitched to the posterior border of the opening, which had been the rima glottidis, and closed the ring completely, thus bringing the epiglottis in contact with the arytenoid mucous membrane, converting the ring into a linear wound running from side to side. The wound was united by continuous catgut sutures. A few strong sutures were introduced into the upper end of the trachea to prevent its slipping down. The result of this operation gave the following advantages over the older methods of operating: (1) The danger to life from inspiration pneumonia was very much less, owing to shutting off the mouth. (2) The patient can swallow as freely as usual. (3) The most wonderful of all, in at least three of the cases, similarly operated, a useful voice, fully as satisfactory as with an artificial larynx, was obtained, and without the trouble that this latter entails. The possibility of recurrence by the irritation of the foreign body—the artificial larynx—could also be avoided. (4) There is less disfigurement than when wearing an artificial appliance. The author followed this method from seeing a patient that was presented by J. Solis-Cohen, who was able to talk easily and audibly with no communication from the pharynx and trachea.—*New York Medical Journal*, October 13, 1894.

Corneal Suture in Extraction of Cataract.—DR. E. KALT says that Dr. H. W. Williams, of Boston, published encouraging results of corneal sutures after cataract operation, in 1867. Others have since recommended the procedure. The author uses a very fine, short, sharp-pointed needle, and thin but strong silk threads. The needles, when armed, are sterilized in hot air and kept for use in sterilized paper envelopes After cocanization and disinfection, he passes the needle through the cornea, in the vertical meridian, about 1 mm. underneath the limbus; the point, without penetrating the anterior chamber, emerges at the juncture of the opaque border, and the thread is drawn. Then the needle is introduced, about 1 mm. above its point of exit, into the scleral tissue, as in muscular advancement. As soon as the point has penetrated the resistant tissue, it is drawn out again in order to involve as little of this tissue as possible. As it is impossible to draw the needle out at right angles, about 2 mm. of conjunctiva is engaged, which is of no importance. In drawing the thread, leave a loop, which is placed sidewise toward the nose, and spread out carefully so as to avoid twisting. In making the corneal incision, care must be taken that the knife passes nicely through that portion of the cornea which the suture has left free. Then the speculum is removed and the cataract is extracted as usual. When the iris is well in position, the assistant raises and holds the upper lid, and the thread is tied. The suture does not inconvenience the patient and is rarely removed before the tenth day. Cutting of the thread with the Graefe knife must be carefully guarded against. In tying the thread one should draw on the superior, scleral end. In 50 cases operated on by the author, by the aid of corneal sutures, there were only two slight hernias of the iris. This showing encourages him to believe that it is an advance in extraction without iridectomy, largely doing away with the objection to the simple method.—*Archives of Ophthalmology*, October, 1894.

Electrolysis as a Treatment for Deviations, Spurs, and Ridges of the Nasal Septum.—DR. WM. L. BALLENGER reports several cases in which the result of treatment of nasal septum deflections were treated by electrolysis with excellent results. The author does not recommend electrolysis to the exclusion of other treatments, but in suitable cases he finds it superior to any other method. He quotes the following *technique* as recommended by Drs. Moure and Bergonié: Each needle is isolated, except so much of the point as is needed to penetrate the bony growth. The needle connected with the negative pole of the battery is introduced into the spur or other thickening in a line with the axis of the nasal fossa, parallel with the septum. The one connected with the positive pole is placed over or above the negative. Do not put the needle too near the base of the deviation, in order to avoid perforation of the septum. The strength of the current should vary from 18 to 25 milliamperes, according to the volume and density of the growth, and should be from 12 to 15 minutes in duration. Often a spur can be removed at one sitting, and recovery is more prompt than after the sawing operation.—*Journal American Medical Association*, November 10, 1894.

The Treatment of Corneal Ulcers by Iodoform, Boracic Acid, and Gelatin Discs.—DR. G. C. SAVAGE makes favorable comment on the treatment of corneal ulcers by the use of iodoform, boracic acid, and gelatin discs, as discovered by Dr. Mules. The method is as follows: Cocainize the cornea, cover the diseased part with one of the discs and apply a bandage. He claimed that the ulcers would be healed under this treatment in three days. He did not change the bandage during that time. Dr. Savage has tried the method in a number of cases and finds that some recover in three days, as Dr. Mules claims. Dr. Savage thinks it best to remove the bandage and reapply a disc each day. The discs have been made by Messrs. Vaughn & Porter, of Nashville, Tenn.—*Ophthalmic Record.*

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M.D., Sacramento, Cal.

The Treatment of Cystitis.—M. LAVAUX believes several remedies to be of real value. Sodium bicarbonate, in thirty to ninety grains, is the remedy of choice when the inflammation is due to irritation, as from cantharides; it is absolutely contraindicated with ammoniacal urines. Sodium borate has a favorable action, according to the doses which are employed; thirty grains seem to act as an alkali; in ninety grain doses it acts as a feeble antiseptic, and is of some value if the cystitis is one of vesical infection, but it is not well borne by some stomachs. Sodium benzoate, benzoic and boric acids are better borne, but appear to be but little more energetic than the last mentioned remedy. More efficacious is salol, but it is a dangerous remedy, and can cause severe accidents. It should be prescribed in from thirty grains to two drachms, the latter being too great. It must be used in small doses if the patient suffers from renal lesions. The pure essence of yellow sandal is quite active in the cystitis of blennorrheic origin, but it often is badly eliminated by the kidneys, which it may irritate; it frequently gives rise to renal pain and, indeed, it may aggravate the cystitis. One drachm to one and one-quarter drachms is a safe dose. Turpentine, even in acute conditions, may be of value, ten drops being a sufficient dose. Buchu is better borne by the stomach than tar, eucalyptus or uva ursi. If mineral waters are used, those of feeble mineralization, as Evaux, are preferred, although in acute cases, Vichy or Vals may be valuable. Pain is best relieved by direct anesthesia of the urethro-vesical mucous membrane. Morphine subcutaneously, opium with belladonna or gelsemine in suppository, chloral by the mouth, may be of value, but they are indirect methods. The direct method by lavage without catheter and anesthesia of the mucous membrane, by cocaine hydrochlorate or nitrate, an antisepsis of the lower urinary tract, are those of choice. The objections to local treatment are obviated when strict antisepsis is obtained, and pain is not caused if the bladder is not distended. A warmed 2 per cent. solution of boric acid is unirritating.—*Chirurgie contemporaine des Organes Genito-urinaires.*—*American Journal of Medical Sciences*, November, 1894.

Treatment of Pityriasis Capitis.—UNNA (*Révue de Thérapeutique Médico-Chirurgical*) offers as the best treatment for pityriasis the following pomade:

Sulphur precipitat.	1 to 3 parts.
Unguent. simplicis	30 parts.

Before applying this ointment the head is washed with potassium soap. At least two applications are made each week; best when done by a barber. This treatment acts as a prophylactic against seborrheic eczema of the rest of the body. When there is marked falling of the hair, it is best to add to the above recipe two to ten per cent. tincture of cantharides. Additional applications may be necessary, when either a pomade of resorcin, two to five per cent., added to sublimate, 1 to 1000, or of sulpho-phenate of zinc, one per cent., may be employed. For the incrusted forms the following may be used:

Zinci oxidi	6 parts.
Sulphur precipt.	4 parts.
Kaolin	2 parts.
Adipis benzoat.	28 parts.

Sig: Two or three applications daily.

For excessive desquamation:

Chrysarobin	2½ parts.
Acid. salicylici	1 part.
Ichthyol	2½ parts.
Vaseline	44 parts.

M. et fiat unguentum. —*Therapeutic Gazette*, November, 1894.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Bichromate of Potassium as a Remedy in Gastric Affections.—We offer the following synopsis of a paper on the above subject, which was read at the International Medical Congress by PROF. T. R. FRAZER: Notwithstanding the assertion made in 1883, by so high an authority as Vulpian, of the value of bichromate of potassium in the treatment of several forms of gastric disturbance, this substance has not yet gained a position among the many substances that are used in the treatment of these affections. Having, in 1884, treated with gratifying success a case of persistent gastric disorder by the administration of small doses of bichromate of potassium, I have since that time administered it in a large number of cases, and the results have been so favorable that I feel myself justified in now stating my opinion of the therapeutic value of the substance. The cases have been recorded in two groups, the first group comprehending 18 cases of various forms of dyspepsia unassociated with evidence of gastric ulcer, and the second group 10 cases in which distinctive symptoms of ulcer had been present at some previous time. The doses administered in the above cases have varied from ½ grain to ⅙ grain twice daily, and in most instances the smaller dose was found to be sufficient. The dose should be given during fasting, and on as empty a stomach as possible. The administration was effected in the form of pills, or an aqueous solution which may be flavored with tolu or orange. An examination of these cases shows that bichromate of potassium is capable of relieving, and often in a short time of removing, the entire group of symptoms—if we except constipation and anemia—encountered in dyspepsia, and especially pain, nausea, vomiting and gastric tenderness. In a few cases of acute gastric ulceration, with hematemesis, in which I have given bichromate of potassium, the results were not favorable, as it did not succeed in checking the bleeding. Bichromate of potassium possesses a strong anti-putrefactive power, which is exhibited in albuminous, saccharine and phosphatic urines, even with a 0.01 solution. This action probably constitutes one of the causes of its anti-dyspeptic therapeutical value, but there are undoubtedly other causes, such as direct or indirect analgesic action, and probably a selective action on the nutrition or function of certain histological structures, which I am now engaged in endeavoring to determine.—*Lancet.*

The Effect of Iodide of Potassium on the Blood.—According to DR. T. V. ISHUNIN, of St. Petersburg, who has examined the blood of 15 patients and 4 healthy persons, before and after taking iodide of potassium, the effect of quantities of this drug, ranging from 15 to 30 grains *per diem*, on non-syphilitic patients and on healthy subjects is, during the first two or three days of its administration, to increase the number of young corpuscles and to diminish the number of over-mature white corpuscles in the blood, and at the same time to increase the number of those breaking up. As to the total number of corpuscles per cubic millimeter, the effect of the iodide appears to be to cause an increase, but a slight one. When the iodide is given to syphilitic patients, the over-mature elements increase in number, and the immature white corpuscles and those which are breaking up decrease.—*Lancet*, September 8, 1894.

Fatal Injection of Cocain.—DR. RECLUS recently reported a case to the Société de Chirurgie, in which immediate death followed a urethral injection of cocain. A man, aged 62, suffered from prostatic retention of urine. Hypogastric puncture was performed, and on the following day renewed attempts to pass a catheter were unsuccessfully made. As a preliminary to a final effort before resorting to a more serious operation, the surgeon injected into the urethra 20 grammes of a 5 per cent. solution of cocain. As 20 centigrammes of a 2 per cent. solution is a more than full dose, the Society was not surprised to hear that the patient of Dr. Reclus' confrère died on the spot.—*Press Médicale.* —*Dublin Journal of Medical Science*, July, 1894.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

The Treatment of Chloro-Anemia.—PROF. RUMMO recommends the following mode of administration of iron in cases of the above infection, for the ensuing reasons: (1) Its applicability in all cases of chloro-anemia. (2) Its intense action on the hematopoietic organs. (3) The possibility of conducting all the iron directly into the circulation. (4) The therapeutic results are rapid. He has employed the various preparations of iron, giving preference, however, to the following solution—

℞. Ferr. Citrit. Ammoniat.................gm. 1.0
Aq. Destil..................................gm. 10.0

Of this solution, ½ to 1 cubic centimeter is injected daily in the interscapular region, and is equal to from 0.05 to 0.10 of the iron preparation. The injections produce no local or general reaction, beyond a slight burning, lasting a few minutes, at the point of injection. An increase in the number of red blood corpuscles is noted after the second injection.—*Wiener med. Presse.*

The Etiology of Chlorosis.—MEINERT directs attention to certain constant anatomical changes met with in typical chlorosis. In 60 cases examined, he found prolapse of the stomach (gastroptosis). Gastroptosis was a manifestation of enteroptosis (intestinal prolapse). Fifteen per cent. of his cases were complicated with wandering kidney of the right side, and in one case movable kidney on both sides was noted. The origin of the prolapse of the viscera was purely mechanical, and provoked by pressure of the liver on the lesser curvature of the stomach and pylorus. The conventional dress of the female, by diminishing the lower thoracic aperture, conduces to this mechanical dislocation of the abdominal viscera. After the apparent cure of chlorosis, the anatomical substratum, visceral prolapse, persists, which explains the frequent relapses of the affection. Women, previously chlorotic, show later in life the symptom complex of hysteria, which can always be referred to the dislocated abdominal viscera. Chlorosis is, as Trousseau has already shown, a neurosis. The foundation of the neurosis is enteroptosis (Glenard's disease). In boys whose thoraces are deformed, as in hereditary phthisis and rachitis, chlorosis is frequently observed. A well-formed, elastic thorax, not deformed by pressure, will exclude chlorosis.—*Münchener med. Wochenschrift.*

Syphilitic Spinal Paralysis.—OPPENHEIM directs attention to this affection, recently described by Erb. The gait is stiff-legged, although relatively there is little muscular rigidity; there is an increase of the tendon reflexes and the motor loss is relatively slight. Unlike the ordinary variety of spastic paralysis, there is almost constant weakness of the bladder and sexual power, and slightly marked disturbances of sensation. The condition requires months or years for its development. There may be improvement after inunction. The patients do not become paraplegic as a rule, as is the case in transverse myelitis. Oppenheim believes that myelitis plays an important role in the clinical history of spinal syphilis. Recent investigations in spinal syphilis have demonstrated that the chief form consists in a meningo-myelitis, the lesion beginning in the membranes. Pathological anatomy has further demonstrated the lesion to be limited to the dorsal cord. The symptoms are not always characteristic, and the prognosis is not favorable, although the disease may show a tendency to improve, to get well, or it may remain stationary.—*Berliner klin. Wochenschrift.*

Cold Compresses in Pulmonary Diseases.—M. C. GENDRE advocates, for acute diseases of the respiratory passages and in acute stages of chronic respiratory diseases, the permanent wrapping of the thorax in cold water compresses. In cases where hyperemia occurs, he has found preferable to all other revulsive measures the permanent wrapping of the thorax in compresses soaked in cold water, wrung out so as to be merely damp, and covered with thin oil-cloth. These compresses should be renewed every half hour or hour, according to the condition of the patient. This may be used with children or even infants. It diminishes dyspnea more rapidly than any other measure, by slowing and amplifying the respiratory movements and by quieting the nervous system. In grave broncho-pneumonia it works admirably. Some advise leaving the patient in a wet pack for two or three hours. Diaphoresis and diuresis are induced by this procedure.—*Médecine Moderne.*

Acute Articular Rheumatism.—A. STOLL has formulated his conclusions on 572 cases of the affection treated during the last ten years, at the Zurich clinic. Half the cases occurred during the third decennium; men were twice as often attacked as women. As causes, cold was cited as the chief etiological factor. The affection began usually with a series of slight chills; 10 times there was a decided chill, and in 16 cases there were prodromata of 1 to 3 days, duration. The frequency of the joints affected does not differ from the conventional percentages. Temperature and pulse increased with the number of involved joints. Endocarditis was observed in 11.6; pericarditis in 3.2, and both in 4 per cent. of the cases. Permanent cardiac troubles resulted in 9.2 per cent. of the cases, of which 6.4 per cent. implicated the aortic valves. As other complications, pleuritis was observed in 3.5 per cent., pneumonia in 1.1 per cent, and bronchitis in 7.2 per cent. of the cases. Chorea was found in two girls and 1 boy; twice with and once without endocarditis. Acute nephritis was observed 4 times, purpura 4 times and manifestations of spinal meningitis, 2 times, In the treatment the salicylates were paramount, and when they failed, antipyrin was usually of benefit; in subacute and chronic cases, iodide of potash was employed. Nearly ⅔ of the cases were discharged in 30 days. There was no case of death. RUEL reports that at the clinic of Genf, acute articular rheumatism was successfully treated by the external application of salicylic acid. The solution employed was as follows: Salicylic acid, 10 to 30 grammes; absolute alcohol, 100 grammes; castor oil, 200 grammes. Cloths saturated with this solution were applied to the joints and renewed morning and evening. These applications, says the writer, have the same effect as salicylic acid taken internally. Twenty minutes after the application, salicylic acid can be detected in the urine.—*Centralblatt f. klin. Medicin.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Auto-intoxication as a Factor in Mental Disorders.—DRS. REGIS and C. LAVAURE submitted a report on this subject at the last meeting of the French Congress of Mental Medicine. They arrived at the following conclusions: (1) The toxicity of the urine is notably diminished in maniacal and augmented in melancholic conditions. The urine of maniacs and that of melancholiacs have different actions on the animals in which they are injected: The former causing chiefly excitation and convulsibility, and the latter depression, inquietude and stupor. This would rather prove that auto-intoxication is the cause and not the effect of the mental state. (2) These results, though incomplete, show that the phenomena of auto-intoxication play an important part in mental diseases, and this is further indicated by recent nosological investigations on the insanities of the acute infectious diseases, and those of the visceral and diathetic disorders. As far as the psychoses of the infectious disorders are concerned, they are the result either of the direct action of the microbes or of their mediate and indirect action through the toxines they secrete. From a clinical point of view they may present themselves at two different periods. During the febrile stage the disorder ordinarily takes the form of an acute delirium. During the post-febrile stage, or during convalescence, we find the so-called asthenic psychosis present; this is a more or less variable mental condition, consisting usually of a mental confusion, stupidity, clouding of the faculties, a pseudo-dementia. An intermediate form between these two may possibly be admitted to exist. The visceral psychoses are in reality genuine insanities from auto-intoxication. It may be said that where the intoxication is acute it shows itself as an acute toxic delirium, resembling alcoholic delirium, as in uremic insanity; when the intoxication is chronic it generally induces a melancholic condition. Some cases resemble more or less paretic dementia. General or local anti-infectious antiseptic treatment is found to give excellent results. Although it is not possible to formulate a definite therapeusis, there are enough facts to show that in the infectious or auto-toxic insanities one must resort to the treatment of the infection or the auto-intoxication to relieve the mental disorder.—*Progrès Médical.*

The Alleged Increase of Insanity.—DR. D. HACK TUKE read an interesting paper on this subject at the meeting of the British Medical Association. Dr. Tuke says there undoubtedly has been a large increase in the number of patients in asylums and workhouses in England since 1870, and proportionately more in the asylums; there has also been a considerable rise, though not as great, in the admissions of patients into asylums during the same period, after deducting transfers and readmissions. This advance in the number under detention, although it holds good after allowing for the increase of population, does not prove the increased liability of the community to insanity, seeing the vast accumulation due to a lower death-rate (since 1870), the chronicity of the disease, and the lamentable tendency to relapse. Nor does the advance in admissions prove increased liability to insanity for the following reasons: (1) The value and comfort of asylums are increasingly appreciated. (2) There has been a very large number of patients transferred from workhouses to asylums; and (3) There has been an ever-increasing encroachment on the mass of unregistered lunacy, which the census shows to exist. The apparent increase in the number of the insane has been found to take place especially among the poorer classes of society. The increase in the ratio of the insane, during the twenty years from 1871 to 1891 has taken place in persons above the age of forty-five, the significance of which lies in the accumulation of chronic cases. On the other hand, there has been a decline during this period in the proportion of cases of mental weakness under twenty-five years to the population at the same term of life—a most remarkable circumstance. Although the increase in the number of the insane has been considerable from 1871 to 1891, the ratio of increase has been a declining one, for though the rise in the ratio to the population was 7.04 per cent. during the decade 1871-1882, it was only

3.23 per cent. in that of 1881-91.—*Dublin Journal of Medical Science*, July 1894.

The Psychoses of the Climacteric Period.—PROF. P. J. KOWALEWSKI, of Charkow, in a recently published paper, "Der Menstruationsznstand und die Menstruations Psychosen," says that during the climacterium insanity may appear in two forms: in the one, the course of the disease is periodical, and the attacks accompany the menstrual periods, or occur at the time when these periods are expected but do not appear; in the other, the psychosis has no direct connection with the menstruation, but seems intimately related to all the symptoms of the climacteric. The mental symptoms of these psychoses vary greatly. They may be characteristic of anxietas precordialis, melancholia, mania, amentia, or paranoia, etc. Although these symptoms are not especially characteristic, the influence of the climacteric may be easily recognized. Thus, the anxietas precordialis occurs in more or less regular attacks, corresponding to the time of the expected menstruation. The same may be said of the periodical exacerbations of hysterical and epileptic attacks. It is often found that at such times sudden changes in mood and character may develop without such symptoms being characteristic of either melancholia or mania. The melancholia of the climacteric period is especially met with in married women leading an unhappy domestic life, and is often accompanied by attempts at suicide. Sometimes the melancholia is of a hypochondriacal type; at other times it is associated with delusions of a religious character, persecutory ideas, or erotic hallucinations. Mania is a rather uncommon form of insanity during the climacteric, and is generally characterized by hallucinations, sexual excitement, violence, phantastic ideas and obscene behavior. It is usually met with in widows, old maids of not very high morals, and, generally speaking, in persons with unsatisfied sexual cravings, or in such who have committed excesses in venery. Amentia does not often occur during this period in the maniacal form; more often in connection with the menstruation in the form of a periodical psychosis or as an uninterrupted attack, with exacerbation corresponding to the menstrual periods. It is often accompanied by an extreme erotism. Particularly characteristic of the climacteric period is paranoia, occurring mostly in old maids with a psycopathic predisposition. The morbid ideas of such persons are concentrated about men, who make love to them on every occasion. They finally accuse their persecutors of having made criminal assaults upon them. The patients believe that a certain man, who is often unknown to them, or may even be living in some other town, maintains marital relations with them. From being persecuted, the patients finally become persecutors, who torment their victims with letters, or even go so far as to make an open scandal of it. In some cases a perversion of the sexual instinct may show itself by persons of their own sex having an attraction for them. These persecutory ideas as regards the men, in which hypnotism, spiritualism, the telephone, etc., figure extensively, together with the sexual delusions and nymphomaniacal symptoms, are so often met with in the climacteric period that this form may be considered the climacteric insanity *par excellence.—St. Petersburger medicinische Wochenschrift.*

A Case of Chronic Arsenicism.—DR. MATHIEW recently reported the case of a man, aged 50 years, affected with neurasthenic depression, who for twenty years had been taking arseniate of sodium in large doses to clear his voice and give him strength. He had been in the habit of using a ½ per cent. solution of arseniate of soda, a pint of which would last him a month. The daily doses would average 3 to 4 centigrammes, or a little over a half a grain. While on a voyage to Algeria, the patient increased his doses, when he was taken sick with symptoms of acute arsenical poisoning, characterized especially by phenomena of intense gastro-enteritis, with profuse diarrhea. The diarrhea lasted for three or four months, at the end of which time cutaneous pigmentation appeared, which has been constantly growing worse. The pigmentation gave the skin a bronzed, tawny or slate-color, varying in places. The face presented no pigmentation. On the palmar surface of the hands is found a marked degree of hyperkeratosis; on the feet this is less pronounced. The nails of the toes and fingers are unequal, irregular, deformed and grooved. Muscular atrophy in the lower extremities resulted. In addition to this there was a degree of uncertainty in walking when the patient keeps his eyes shut, and at one time there was almost a complete paralysis of the lower extremities. The pupils react well to light. Some hyperesthesia is present over the sole of the right foot. These phenomena may be explained on the theory of the existence of a peripheral neuritis. The use of the arsenic, to which he had been so long addicted, must be regarded as the principal, if not the only factor, in the production of the nervous symptoms. The patient had never used alcohol to excess.—*Journal of Nervous aud Mental Disease.*

General Paralysis in Women.—DR. F. A. ELKINS reports 28 cases of general paralysis in women admitted to the Edinburgh Insane Asylum during the five years 1889 to 1893. The age of the patients varied from 25 to 51 years, and averaged 40. In 2 cases, a history of heredity was present. The cases were, as a rule, individuals who were not physically or intellectually deficient, but who were of a low moral character; the personal histories generally gave a record of syphilis, alcoholism, and sexual excesses. These cases corroborated a fact, already established, that the disease is of a milder type in women than in men. Twenty of the cases were mild, 8 acute. The duration cf the disease was found to be about the same as in men. In 21 cases where death had taken place when the report was made, the duration was less than one year in 3 cases, less than two years in 6 cases, and less than three years in 3 cases. A *post-mortem* examination was made in 14 cases, and in these the pathological findings were the same as those usually observed in men. In 10 cases grandiose ideas were present; 3 cases were suicidally inclined during the early stage of the disease; in 15 cases epileptiform or apoplectiform "congestive" attacks were observed; 5 cases showed well-marked temporary improvements, which did not in any case exceed a duration of fifteen months; 3 cases showed partial improvements.—*Lancet.—Centralblatt f. Inere Medicine*, September 22, 1894.

A Case of Essential Hereditary Tremor in a Degenerate.—DR. VAUTRIN, reports the following observation as a rare case of essential hereditary tremor. The patient was the son of an alcoholic; he suffered from incontinence of urine, and presented various stigmata of degeneration; malformation of the teeth and ears, mental weakness and melancholia. Besides these symptoms he had been affected since his infancy with generalized tremor. His head only remained unaffected. The oscillations were very short and slow, regular and continuing during sleep. They were not increased under the influence of voluntary movements, but were augmented by emotion and fatigue.—*Gazette Hebdomadaire de med. et de Chirurgie.—Journal Nervous and Mental Disease*, July, 1894.

FORMULÆ.

By Geo. B. Somers, M. D., San Francisco, Cal.

Calomel Plaster in Congenital Syphilis.—In the following preparation the sodium chloride and alkaline salts of the sweat transform the insoluble subchloride to the soluble perchloride, which is absorbed and keeps up a continuous action:

Calomel	10 parts.
Castor oil	3 parts.
Diachylon plaster	30 parts.

Four square inches of this plaster ought to contain about 18 grains of calomel. A piece about 6 inches long and 4 broad, is applied, after thoroughly cleansing the skin, and is renewed weekly.—*British Medical Journal.*

Mercurial Paste for Corns.—(Morrison):

Bichloride of mercury	gr. iv
Salicylic acid	ʒi
Collodion	℥i

S.—Apply every day, removing each time the film left by the previous application.—*Nouveax Rémedes.*

Enlarged Glands:

Iodoformi.	
Bals. Peru.	āā ʒi
Colodii	℥i

S.—To be painted over the swellings every night.—*Medical Press and Circular.*

Sluggish Conditions of the Liver:

Podophyllinæ	gr. ¼
Euonymuiæ	gr. iss
Ext. belladon.	gr. ¼
Pil. hydrarg.	gr. ii

For one pill, to be taken at bedtime. *Medical Press and Circular.*

Pills for Chronic Bronchitis:

Ammonii chloridi	gr. xv
Ammonii carbonatis	gr. xv
Pulv. ipecac.	gr. iii
Morph. hydrochloratis	gr. i
Mucilaginis acaciæ	q. s.

Divide into 10 pills, one to be taken night and morning.—*Medical Press and Circular.*

Tricophytosis.—In experiments Du Castel found that the following formula answered best in treating this disease:

Chrysarobin	gm. 10 to 25
Salicylic acid	gm. 5
Ointment of styrax	gm. 5
Ichthyol	gm. 5
Simple ointment	gm. 5

—*Union Médical.*

Alumnol as a Diapasin. — (Dietrich):

Alumnol	gm. 10
Powdered talcum.	
Starch	āā gm. 45

S.—To be used as a powder in blisters, sweating of the feet, etc.—*Nouveaux Rèmedes.*

Evaporating Lotion:

Ammon. chlorid.	℥i
Sp. rectificati	℥ii
Sp. etheris	℥i
Ac. acetic	℥iss
Aq. destillat. *ad*	℥xii

To be applied on lint in severe sprains.—*Pharmacopeia of Royal Infirmary.*

Diabetes Mellitus.—Solis Cohen uses codein in certain cases of this disease in gradually increasing doses up to 12 grains or more daily:

Codein phosphate	gr. ii
Alcohol	ʒiv
Dilute phosphoric acid	ʒii
Glycerin	ʒvi
Solution of hydrogen dioxide (10 volume) to make	℥iii

Dose: two teaspoonfuls in 3 ounces of water.—*College and Clinical Record.*

Chrysarobin Pencil.—(Leistikow):

Chrysarobin	gm. 30
Rosin	gm. 5
Yellow wax	gm. 35
Olive oil	gm. 30

S.—In alopecia rub the above into the hairy scalp at night. The irritation may be met with zinc ointment. *Nouveaux Rémedes*

A Hypodermic Purgative.—Ewald, of Berlin, maintains that a mixture of equal parts of caffein and chloral, injected subcutaneously, will act as a purgative. He uses it particularly in acute rheumatism, where it also acts as a sedative:

Caffein chloral	gr. xv
Water	m. lxxv

S.—Inject 15 minims.—*Journal de Médicine de Paris.*

Phosphorus Butter.—Comby recommends the following prescription for the preparation of iodo-phosphorated butter, which may be used as a substitute for cod-liver oil in hot weather:

Fresh butter	1 lb. 1½ oz.
Iodide of potassium	gr. xv
Bromide of potassium	gr. xv
Chloride of sodium	ʒ ii
Phosphorus	gr. ¼

About one-third of an ounce daily, spread on bread.—*Medical Record.*

PUBLIC HEALTH.

By W. R. Cluness, M.A., M.D., San Francisco, Cal.

Mortality for October, 1894.—The deaths registered in 69 town districts of the State, during the month of October, in a population of 748,873, correspond to an annual rate of 16.32 a thousand, the total mortality having been 1022. 127 deaths were due to zymotic diseases, giving an annual rate of 2.02 a thousand. Of these, 19 were due to diphtheria, 41 to cholera infantum, 27 to typhoid fever, 17 to diarrhea and dysentery, 10 to cerebro-spinal fever, 6 to whooping cough, 5 to croup, 0 to intermittent and remittent fevers, 2 to scarlet fever, 0 to measles, and 0 to small-pox. 250 deaths resulted from diseases of the respiratory organs, giving an annual rate of 3.93 a thousand. Of these, 166 were due to consumption, 63 to pneumonia, 20 to bronchitis, and 1 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.64 and .96, respectively. 91 deaths resulted from diseases of the heart, 9 from alcoholism, 1 from erysipelas, 46 from cancer, and 404 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 587,153, was 16.56 The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Fresno.

METEOROLOGY.

Summary for October.—*Temperature.*—The normal temperature of the State for October is 61.1°; the average for October, 1894, was 61.9°, a departure from normal of + 0.8°. The highest monthly mean was 90.2°, at Volcano Springs, in the desert regions of San Diego county; the lowest, 45.8°, at Boca, in the mountain regions of Nevada county. The maximum temperature was 110°, on the 4th, at Salton, in the desert regions of San Diego county; the minimum, 20°, on the 28th, at Greenville, in the mountain regions of Plumas county. The greatest monthly range was 68°, at Greenville; the least, 30°, at Eureka. The absolute monthly range for the State was 90°.

Rainfall.—The normal precipitation for the State for October is 1.22 inches; the average for October, 1894, was 1.63 inches, a departure from the normal of +0.41 of an inch. The greatest monthly precipitation was 9.65 inches, at Dunsmuir; the least, 0, at several stations in the southern portions of the State.

Wind.—The prevailing direction of wind was west.

Unusual Features.—The unusual meteorological feature of the month was the excess in rainfall.—James A. Barwick, Director California Weather Service.

California—Tabular Statement for October, 1894.

STATIONS.	Temperature.						Rainfall.		Mean Relative Humidity	Weather.			Wind.	Furnished by—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn.......... Cal.	65.0	90	50.0	---	---	---	---	3.87	---	---	---	---	N.W.	Southern Pacific Company.
Berkeley......... "	59.0	86	47.0	66.0	53.0	13.0	5	3.29	88.0	20	7	4	W.	Obs. University of California.
Colfax.......... "	57.0	96	42.0	---	---	---	---	5.75	---	---	---	---	S.E.	Southern Pacific Company.
Eureka.......... "	54.0	69	39.0	60.0	48.0	12.0	13	3.12	89.0	8	12	11	N.W.	Weather Bureau Dept. Agr.
Fresno.......... "	64.0	92	42.0	77.0	51.0	26.0	2	0.37	64.0	22	7	2	N.W.	" " "
Indio.......... "	79.0	105	56.0	---	---	---	---	0.00	---	---	---	---	W.	" " "
Los Angeles.... "	66.0	96	45.0	78.0	53.0	25.0	1	0.02	75.0	10	16	2	W.	" " "
Monterey....... "	58.0	84	40.0	---	---	---	---	1.64	---	---	---	---	S.	Southern Pacific Company.
Napa.......... "	62.0	91	45.0	72.0	52.0	20.0	5	1.93	78.0	13	13	5	S.	Station Napa Insane Asylum.
Oakland......... "	59.0	84	45.0	67.0	51.0	16.0	5	2.64	86.0	18	9	4	W.	Chabot Observatory.
Paso Robles.... "	61.0	93	37.0	---	---	---	---	0.88	52.0	---	---	---	N.	Southern Pacific Company.
Red Bluff....... "	64.0	95	43.0	75.0	53.0	22.0	7	0.89	63.0	19	4	8	N.W.	Weather Bureau Dept. Agr.
Sacramento.... "	63.0	92	43.0	75.0	51.0	24.0	5	1.06	67.0	27	1	2	S.E.	" " "
San Bernardino "	65.0	96	38.0	80.0	49.0	31.0	2	0.15	61.0	20	8	3	W.	A. K. Johnson, M. D
San Diego....... "	63.0	87	45.0	70.0	55.0	15.0	1	T.	76.0	18	6	3	N.W.	Weather Bureau Dept. Agr.
San Francisco.. "	60.5	89	49.0	66.0	54.0	12.0	5	1.73	82.0	17	9	5	S.W.	" " "
Santa Barbara.. "	66.0	94	50.0	74.0	58.0	16.0	2	1.36	73.0	18	7	6	W.	Hugh D. Vail.
Santa Cruz...... "	61.0	94	42.0	72.0	51.0	21.0	5	3.59	---	20	1	10	W.	W. R. Springer.
Yuma.......... A. T.	75.0	101	47.0	91.0	58.0	33.0	1	0.84	48.0	27	4	0	N.E.	Weather Bureau Dept. Agr.

Relative humidity at Paso Robles at 2 P. M.

Blank (----) indicates data missing.

Occidental Medical Times.

Communications are invited from all parts of the world. When necessary to elucidate th text, illustrations will be furnished without cost to the author.

Sacramento: December, 1894.

THE COMMENCEMENTS.—UNIVERSITY OF CALIFORNIA MEDICAL DEPARTMENT.

The graduating exercises of the medical department of the University of California were held in Odd Fellows' Hall, San Francisco, November 20th. In addition to the address on behalf of the Faculty, which was delivered by Prof. J. M. Williamson, the graduates were addressed by the Hon. J. V. Coleman, who congratulated them upon the position to which they had attained, and also upon the increasing eminence of their Alma Mater.

The following are the names of the graduates: John Richard Booth, Edwin Bunnell, A. B.; Stephen Cleary, Ph. G.; George Waverley Clark, Robert Crebs, Edward Spence DePuy, Clarence Fitzhugh Dickenson, Frank Timothy Fitzgibbon, Charles Henry Freeman, August Greth, Edward John Hill, Thomas Blakeney Holmes, Thomas Byers Woods Leland, Martin Bartholomew MacInnis, Nellie Mattie McKnight, Frank Edward McCullough, Mary Elizabeth Morrison, Joseph Grant Morrissey, Casimir Francis Pawlicki, B. Sc.; Fenelon Massol Reith, Corydon Bee Root, D. D. S.; Henry Anthon Lewis Ryfkogel, Nathalie Adele Selling, James Graham Sharp, D. D. S.; Neli Alfred Sime, Harvey Foster Smith, Henry Walter Stirewalt, James Goodwin Thompson, Edward Vester Tiffany, Farrington Wilkes, Henry Eugene Wright.

The total number of students in attendance during the past session was 145, the number of matriculates being 66.

NOTES.

San Francisco Society of Eye, Ear, Nose, and Throat Surgeons.

Judging by the attendance at the November meeting of this Society, the members are losing interest since the novelty of the organization has worn away. Last winter the meetings were well attended, at least 75 per cent. of the members being present at the various meetings. This fall, only 25 per cent., a bare quorum, have attended the meetings. While these members are thoroughly in favor of continuing the organization, having found sufficient to both interest and instruct at the various meetings, they feel that their endeavors will prove futile unless all are more interested, as each member owes a greater debt to the Society than is liquidated by the mere payment of the annual dues.

A Naval Medical Board.

A Medical Board for the examination of candidates for admission into the Medical Corps of the Navy, is in perpetual session at the U. S. Naval Hospital, Mare Island, California. The "Board" consists of Medical Inspector G. W. Woods, President; Surgeon G. P. Bradley, member and T. A.; Surgeon George Rothganger, member and Recorder. The President, who, being appointed from California, takes a great interest in the schools of this coast, has, during the last month, addressed the full class, at both Cooper College and at the University. He presented all the main features of the service, explaining the character and requirements of the examination for entrance, and, incidentally, describing naval life and experience, ashore and afloat, through an account of hospital duty, and the incidents of a typical foreign cruise. He invited the graduating students in selecting a career, to consider the merits and advantages of the naval medical service, as well as the opportunity offered for admission by a "Board" organized for their special advantage. Circulars issued by the Navy Department, giving all necessary particulars, can be obtained on application to the office of the Secretary of the Navy, or to the President of the Examining Board, Navy Yard, Mare Island, California.

The Ohio Pure Food Law and "Vin Mariani."

Prof. C. T. P. Fennel, of Cincinnati, Chemist for the Ohio Food and Dairy Commission, and who made the analysis of "Vin Mariani" on which Mr. John Keeshan, a druggist of Cincinnati, was arrested on the charge of violating the Ohio Pure Food Law in the sale of "Vin Mariani," the claim being made by Prof. Fennel that the preparation was not up to the standard within the meaning of the law, has now acknowledged that he has made a mistake in establishing what the standard is, and that he had not, at the time of making his analysis, examined the latest edition of the United States Dispensatory, and that "Vin Mariani" is clearly and completely up to standard as established therein. The case against Mr. Keeshan for the sale of "Vin Mariani" is thereby disposed of, and Prof. Fennel has also authorized the public announcement through the press of the fact that the sale of "Vin Mariani" in the State of Ohio is perfectly lawful, and such sale cannot be interfered with under the laws. The following are the sections bearing on the case, Section 1. That no person shall, within this State, manufacture for sale, offer for sale, or sell any drug or article of food which is adulterated within the meaning of this Act. Section 3. An article shall be deemed to be adulterated within the meaning of this Act: (1) If, when sold under or by a name recognized in the United States Pharmacopeia, it differs from the standard of strength, quality, or purity laid down therein; (2) If, when sold under or by a name not recognized in the United States Pharmacopeia, but which is found in some other pharmacopeia, or other standard work on materia medica, it differs materially from the standard of strength, quality, or purity laid down in such work. (3) If its strength, quality, or purity falls below the professed standard under which it is sold.

Insurance Examiners' Meeting.

A call is hereby made for a meeting of life insurance examiners and local surgeons of accident insurance companies, to meet in Parlor "B" of the Portland Hotel, Portland, Oregon, on Wednesday, January 23, 1895, at 10 o'clock A. M. All regular accredited examiners in good standing, residents of Montana, Idaho, Oregon, Washington, California and British Columbia, are invited to take part in such meeting. The principal work of this first session will be to complete the organization of Pacific Coast Examiners. Papers will also be read at this meeting upon subjects in line with the work sought to be accomplished by the Society. Papers have already been promised, and others are solicited. The membership fee will be $1, which will include the first year's dues. Members who can not attend in person can delegate their votes to some friend or neighbor who can attend, and thus every region may be represented by its membership, no matter how remote such region may be from the place of meeting. When fully organized, a neat certificate of membership will be issued. Temporary certificates will be issued at the time of making application for membership, entitling the holder to take part in the preliminary organization and meeting. In addition to the benefits which will result to those who shall be able to attend the meetings and take part in the discussions, a roster of membership of the Society will annually be issued, and a copy filed with every life and accident insurance company doing business in the country. Any physician, qualified as before mentioned, desiring to become a member, should write at once to Dr. Henry W. Coe, Acting Secretary, Portland, Oregon, making application. Statement should be also made whether such applicant will be present at such meeting; also, whether a paper will be presented, and, if so, its title. It has been thought advisable to hold the meetings of this Association hereafter at the time and place of one of the different State Medical Society meetings, and by a rotation of the place of meeting to enlarge the scope and usefulness of the Association. With a desire to liven interest in the important department of work of the physician and surgeon covered by life and accident service, and to benefit the local practitioner and the companies he represents, we remain yours truly, C. K. Cole, M.D., Referee Equitable Life of New York, Helena, Montana; J. B. Eagleson, M.D., Referee Mutual Benefit Life of Newark, Seattle, Washington; Henry W. Coe, M.D., Referee Penn Mutual Life of Philadelphia, Portland, Oregon, temporary committee.

California College of Pharmacy.

The subject of the proper preliminary education of students in pharmacy, and the evident lack of sufficient qualification in many desiring to matriculate, has long been recognized by the Faculty of this College. Discussion finally resulted in the appointment of a committee, consisting of Prof. Wm. M. Searby and Prof. Jerome B. Argenti, and we give below the result of their deliberations. This report has been adopted by the Board of Trustees, and the recommendations constitute the requirements for admission for the session of 1895. Pharmacy is so closely related to medicine that the graduation of a better class of druggists will be received with much satisfaction. Your committee have given much thought to the subject committed to them, have examined the requirements of the principal colleges of pharmacy in the United States, and of the Medical and Dental Departments of the University, feeling that it is desirable that our college should be in line with other pharmaceutical colleges, and also that our graduates should have the necessary general education to enter either the Medical or Dental Department of the University after graduation by us, should they so desire. We find a wide diversity in the requirements for entrance in the various colleges of pharmacy, a few admitting without any credentials or examination, the majority being satisfied with a certificate of gradution from a grammar school, and a few demanding a higher grade of scholarship. In general, the University Schools of Pharmacy, such as Ann Arbor, Wisconsin, Washington and the North-Western University, have set their entrance requirements higher than the others. In view of the close affiliation of our college with the State University, and our near relation to the departments of medicine and dentistry, it is the opinion of your committee that the interests of our college will be best served by an advance that will place us on an equal footing educationally with those departments. Your committee are also profoundly impressed with the conviction that we should not only be able to graduate a higher percentage of those who come to us than we do now, but that those graduates would do us more credit in after life, and, what is most important of all, that the students themselves would gain greatly if we should compel them to obtain a more liberal education before entering our classes. Furthermore, we believe that those who have neither the ability nor the application to bring themselves up to the educational standard we now recommend, would be benefited rather than injured by being denied the privileges of the college. While the matter of an extension of the course of instruction so as to cover three instead of two years is not strictly within the province of your committee, we would call attention to the fact that such an idea is gaining currency, and that rumors are in the air that this step will soon be taken. We consider such a change would be premature, so long as the requirements for admission remain as they are. We are filled with surprise at one of the largest eastern colleges announcing that the three-term course will shortly be inaugurated, while they have never yet announced any positive requirements in regard to admission. Under such conditions, it seems to us that to extend the course of instruction through a third year is like raising another story upon a house that has been built upon a very frail foundation. In this connection we call attention to the action of the Medical and Dental Departments, which announce that at an early date they expect to extend their curricula another year, but have very wisely elected to make the work of that year precede the present course of instruction, so that it will consist of studies preparatory to those at present given in the various branches of their respective professions. Their action in this particular harmonizes with our experience that the instruction now provided and the time now devoted to it are sufficient, provided the student enters upon the work equipped with a liberal education. You committee beg leave, therefore, to make the following recommendations: (1) That the paragraph at the head of page 9 of the Prospectus for 1894 be stricken out, and the following substituted: "*Requirements for Admission*—(1) Applicants for admission must be at least eighteen years of age. (While it is advisable that students shall have one or two years' practical training in a drug store before entering the college, this is not compulsory.) Applicants will be accepted who bring the following credentials: (*a*) Certificates of graduation from high schools of this State. (*b*) Diplomas of graduation from schools or academies accredited by the State University. (See Register of the University of California, 1894, page 39.) (*c*) Certificates of high standing in other institutions of the collegiate grade. (*d*) Diplomas from normal schools of this State. (*e*) First-grade teachers' certificates of this State. (*f*) Certificates of having completed satisfactorily the first year's course in high schools of this State. (3) Applicants who do not present any of the foregoing credentials will be examined in the following branches: (*a*) English—They will be required to show their ability in spelling, punctuating, use of capitals, grammatical construction and correctness of expression. (The handwriting will be estimated and form a part of this examination.) (*b*) Geography—American and General; free-hand drawing. (*c*) Mathematics—Arithmetic: fundamental rules; fractions, common and decimal; denominate numbers; percentage; proportion. (*d*) Algebra: fundamental rules; fractions; equations of the first degree, consisting of two or more unknown quantities. (In the session of 1895 applicants may be excepted from this examination, but in the year 1896 it will be enforced.) (*e*) Latin—Rudiments; declensions of nouns, pronouns, adjectives; conjugations of verbs; translation of simple sentences from Latin to English and English to Latin. Applicants who fail to obtain the required percentage in free-hand drawing and Latin may be entered conditionally, but will be required to pass the examination satisfactorily in these studies at the close of the Junior Lecture Course. (2) We recommend that the entrance examination be conducted by a committee of three chosen from the Faculty and Board of Trustees, who shall employ a person not connected with the College, who is, or has been, a teacher by profession, such person to be paid for his services by the College. At the close of these examinations this committee shall report to the Dean the names of such applicants as have passed their examination satisfactorily. The Dean shall thereupon matriculate them as regular students. (3) Your committee further recommend that all applicants who are required to pass an examination before entering be charged a fee of five dollars, which is not to be returned in case of failure. But all who pass the examination satisfactorily shall be entitled to matriculate without further payment. The requirements here recommended do not go beyond the studies taken in the first year of our high schools, and would be on a par in the subjects specified with the qualifications now exacted by the Dental Department, and about to be adopted by the Medical Department. Should the two departments named carry out their proposed fourth or preparatory year, it might be advantageous for us to unite with them. Arrangements could doubtless be made so that pharmacy students could obtain suitable instruction. This course would be conducted under the direction of the faculties, but away from the college premises, and would include Latin and the other studies taken in the first year in the high schools, with some branches specially designed to prepare for the medical, dental and pharmaceutical courses that would follow. Those who have had the higher education would not need to take this course."

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, October 23, 1894.

The President, W. F. WIARD, M.D., in the Chair.

Removal of the Astragalus.—DR. T. W. HUNTINGTON exhibited two cases of entire removal of the astragalus. The cases had each, in less than one year, a fairly good ankle-joint, there being ¾ of an inch of shortening.

DR. G. A. WHITE read a paper on "Perinephritic Abscess."

DR. W. A. BRIGGS, in opening the discussion, said: The title of the paper leads me to make a slight criticism. I believe "perinephric," is the preferable term. The paper is an interesting one, as these cases are not always recognized, and the prognosis is very uncertain when an accurate diagnosis has not been made.

DR. J. H. PARKINSON: I think the doctor's success is due to the 4-inch incision and the drainage tube. The term "perinephric" will, no doubt, be adopted in the future by the advanced "practician," but for the present we must get along as best we can with perinephritic.

DR. T. W. HUNTINGTON: Early diagnosis and the exact cause which gives rise to the lesion determines the gravity of the individual case. The simplest case is that due to traumatism. The outcome of these cases, if the treatment be prompt, is favorable. Those cases accompanied by pyelo-nephritis, where the abscess is within the parenchyma of the kidney, are always serious. The treatment is, however, the same, and prompt treatment gives the best results. The relief of tension in cases with a rise of temperature and pain, accompanied with some elevation of the tissues in the region of the kidney, should be prompt.

DR. THOS. ROSS: I saw the case mentioned by Dr. White, and was much impressed with the resistance and consolidation of the lung after all the inflammatory conditions had subsided.

DR. D'ARCY POWER: While practising in Portland, Oregon, I was called to see a man who had three weeks previously fallen into the river. He had severe pain in the right leg, which fomentations did not relieve. The temperature was 104° F., with a pleuritis on the affected side. The presence of pus in the region of the kidney was suspected, and an incision on the left side evacuated 20 ounces of pus. The patient made a good recovery.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, October 9, 1894.

The President, W. WATT KERR, M.D., in the Chair.

The So-called Hemorrhagic Diathesis.—DR. C. G. KUHLMAN read a paper upon this subject. He said the literature upon this important and very imperfectly understood subject was exceedingly scant, Rindfleisch even failing to mention it in his work on pathology. Virchow, in his cellular pathology, refers to it briefly and vaguely, stating that it is due to a change in the chemical composition of the blood, and that the spleen or liver are the special organs influencing this chemical composition, but fails to explain the *modus operandi*. While it is true that the chemically altered condition of the blood plays a very important role in this tendency to uncontrollable bleeding, yet, no matter how altered this composition may be, it cannot be considered as the prime factor, nor do the liver or spleen play any part whatever therein. The use of such terms as "diathesis" is, to a great extent, responsible for existing ignorance regarding many similar processes; thus, the term hemorrhagic diathesis does not convey a true conception of the factors concerned in the disease. This inherited or acquired tendency to severe and often uncontrollable bleeding upon slight provocation, must be regarded as an abnormal pathological condition on the part of the tissues entering into the composition of the blood vessels as well as of the blood itself. With rare exceptions, this hemorrhage takes place from the arterial system. The arteries, with the exception of the smallest capillaries, consist of three coats: (1) An internal or endothelial. (2) A middle and muscular. (3) An external or fibrous. In the normal condition, these tissues, especially the middle coats, are endowed with certain physical properties, as elasticity, contraction and retraction. Loss of arterial continuity under normal conditions never occurs, except through violence, and in such cases a hemorrhage is immediately and permanently stopped by natural means, as contraction and retraction of the tissue with clot formation, provided that complete loss of continuity takes place, if good-sized vessels are involved. The so-called hemorrhagic diathesis, therefore, depends upon the loss of these properties in the vessel walls as well as in the altered condition of the blood itself. The histological elements of which the arterial tunics are composed undergo certain changes, impairing or totally destroying their anatomical and physiological processes. These changes are: Granulation necrosis occurring in tuberculosis, syphilis, leprosy, etc., and due to direct chemical changes between the physiological products of certain organisms aud the protoplasm of the histological elements. Amylosis occurring during extensive suppuration processes, and due to a similar direct change. Coagulation necrosis or mucoid degeneration observed in cancerous and diphtheritic processes. Liquefaction necrosis occurring in typhus, variola, etc. Fatty and calcareous degeneration in which the protoplasm is replaced by fatty granules and crystals of carbonate and phosphate of lime. The precise etiological factors concerned in the production of these changes are as yet *sub judice*. The blood also belongs to the mesoblastic tissues, and during this morbid process undergoes changes that impair or destroy its capacity for coagulation. The hemorrhagic diathesis, then, is not a mysterious condition of the blood induced by some unknown cause, but rather a very important symptom pointing to a grave condition of an arterial or venous trunk or of the whole vascular system, demanding the highest therapeutic and surgical skill in its management.

DR. S. S. HERRICK said heredity seemed inexplicable as a cause of hemophilia. Probabiy 11 out of 12 cases occur in males, and in this respect it resembles color blindness. It sometimes skips one generation, and then is inherited from the daughters only. Ergot, perchloride of iron and gallic acid are the chief remedies for the disease. The great need was some preventive measure.

DR. KUHLMAN: I cannot agree with Dr. Herrick as to the dormancy of the disease. It is inherited *in utero*. Some of the children of syphilitic and tubercular parents may escape. The reappearance of the condition after the lapse of a generation must be regarded as the result of intermarriage with women suffering from constitutional diseases, capable of transmitting the pathological condition upon which the hemophilia depends.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, September 15, 1894.

The President, JOHN F. MORSE, M.D., in the Chair.

DR. J. M. WILLIAMSON read a paper on a human monstrosity, and exhibited the specimen and photograph, at the same time demonstrating the points of interest.

DR. WASHINGTON DODGE said: I was one of the physicians present, but cannot now add anything of interest to the description given by Dr. Williamson. The delivery was easy after the fingers could be hooked between the jaws, thus enabling traction to be made.

DR. W. S. THORNE and **DR. EMMET RIXFORD** reported a case of a protozoic skin disease [published at p. 704].

DR. THORNE said: The patient was an inmate of St. Mary's Hospital. Upon first examination the urine was quite smoky and showed the presence of blood. Now, however, the urine is all right, though scanty. I invited Dr. Rixford to examine the patient, and submitted to him for microscopical examination a patch, excised from over the right clavicle. He has made sections of it, and will now exhibit them.

Dr. Rixford said: About a year ago there came to the City and County Hospital a man suffering from a skin disease, which was evidently of unusual character. Among other affections suggested by way of diagnosis, cutaneous tuberculosis seemed to be most in accord with its characteristics. A patch was excised and sent me for microscopical examination. As stated in my report sections showed a condition greatly resembling tuberculosis, and it was thought to verify this by staining for the tubercle bacilli. No bacilli were found, but in their stead the spherical organisms described in my report. These are most probably protozoa, since they have a distinct capsule and multiply by sporulation. They stain irregularly; in the same section some stained red with the fuchsin, while others took the methyl blue. Hematoxylin stains them, but weakly. This case of Dr. Thorne's is apparently identical with the other; the lesions are much alike, and both contain these spherical organisms, which if not identical, are certainly closely related. There are some slight differences to be made out in them, however, in arrangements of the spores. It is to be regretted that Dr. Thorne's patient is this evening in such a depressed condition that he could not be brought before the Society; for the characters of the lesion are much easier demonstrated on the patient than by verbal description. These photographs of my case, taken in November of 1893, give a fairly good idea of the gross appearance of the lesion, and these micro-photographs, kindly made for me by Dr. W. F. Arnold of the navy, show the organism quite plainly in the interior of a giant cell. Dr. Thorne has called attention to the extensive tumefaction of the lymphatic glands of the neck and groin. In the other case the lymphatics were not involved until much later in the disease.

Dr. Douglass W. Montgomery: This case, and the one previously seen by Dr. Rixford, are of special interest at the present time. As all of you have noticed, the medical journals have been lately full of the question of psorospermosis, and its possible etiological relationship with cancer. In 1888 Neisser strove to show that molluscum contagiosum was caused by coccidia or psorosperms, a class of monocellular organisms belonging to the sporozoa. In 1889 Darier and Thibault discovered what they supposed to be psorosperms in an affection of the skin, which they called psorospermose folliculaire vegetante. In 1890 Darier and Louis Wickham announced that they had found bodies, which they called "psorosporms" in that "disease of the mammary areola preceding cancer of the mammary gland," now called "Paget's disease of the nipple." They said these bodies were found constantly and in numbers corresponding to the intensity of the disease process. The coccidial origin of the above diseases has been received with such favor in some quarters that they have been given a separate consideration by Brocq in his work on "Diseases of the Skin," and classified as follows: Psorospermoses—(1) Molluscum contagiosum. (2) Psorospermose folliculaire vegetante. (3) Paget's disease of the nipple. (4) Some cases of superficial cancer, supposed to be identical with Paget's disease of the nipple, but affecting other parts of the cutaneous surface. Now, if psorosperms are found constantly, and in numbers corresponding to the intensity of the disease process in every case of Paget's disease of the nipple, and if we know that every case of Paget's disease of the nipple is sure to be followed sooner or later by cancer of the mammary gland, then it is hard to escape from the inference that these psorosperms must stand in a closer relationship to this form of cancer than the mere chronic irritation they set up. But Neisser, on further investigation, seems to doubt the presence of coccidia even in molluscum contagiosum, and to deny all proof of their existence in any of the other diseases. And it must be said that the majority of those who have gone over this ground carefully are as skeptical as Neisser; for instance, Karg, who has worked on Paget's disease, and McCallum, of Toronto, who has investigated molluscum contagiosum. Much doubt has also been thrown on the coccidial origin of the disease called psorospermose folliculaire vegetante by many observers; for instance, by T. P. Pawloff, who finds that the so-called psorosperms in a case examined by him are changed epithelial cells. But the round bodies having a capsule in Dr. Rixford's case, are not altered epithelial cells, and one can see capsules with their contents, empty capsules, capsules in which young individuals have formed and other capsules which have burst, allowing these young individuals to escape. There seems hardly a doubt that we have here the long-looked for psorospermosis of the skin. It, however, does not give rise to epithelial proliferation as coccidial disease, or the "wet snout" of rabbits does, but to a disease strikingly like tuberculosis of the skin, both clinically and histologically. This similarity to tuberculosis renders it imperative to make the differential diagnosis carefully. Neither of the patients has tuberculosis of the lungs; tubercle bacilli have not been found in the lesions although looked carefully for; the inoculation experiments in rabbits have not given rise to tuberculosis, and the disease is wide spread and destroys tissue rapidly. As Dr. Rixford has told us, it is supposed that there is only one other case of this peculiar affection described, and we may congratulate ourselves on the discovery of such an important disease here. I look upon this as being one of the four noteworthy events in the medical history of San Francisco, the other three being the application of the actual cautery to corneal ulcers by the late Dr. Martinasche, a most notable thing in its day; the recovery, under Dr. Morse, of two cases of abdominal aortic aneurism operated on by Loreta's method, and the perfection of the crushing operation for stone in the bladder by Dr. George Chismore.

Dr. R. W. Baum read a short paper on "Typhoid Fever Treatment by Baths." He said: In the German Hospital, when I first went there, we had no movable baths and relied more on sponging, etc. From August 14th to November 29th, when the movable baths were put in, we had ten cases of typhoid—three died. One case was brought in almost dying; the two others died about the fifteenth or twentieth day. Percentage, 20 to 30; extra large. From November 7, 1892, to 1894, of 45 cases, 8 per cent. died. Two were dying when brought in, and one died in two days. We continue the bath for ten or fifteen minutes; one or two during the day where the temperature was 102.5° or above. Both were started at about 90°, and lowered by addition of cold water to 70°. As to treatment, it was mainly expectant; no antipyretics till convalescence, and when the fever remained along about 102° or less, a dose of phenacetin or quinine was given at evening. In the way of stimulants we gave usually strychnin, rarely alcohol, and not at the beginning but towards the latter part of the disease. As an aid to the diagnosis the diazo reaction assists very much. It is also found in measles and tuberculosis, pneumonia, but it is different somewhat from that obtained in enteric fever. In all the cases it was found. It consists of the reaction of 1 part of a solution of nitrite soda (½ gm. in 100 gms. water), and 50 parts ot a solution of sulfanilic and hydrochloric acid (10 gms. in 200 gms. water). To one part of this mixture an equal part of urine is added, and to the mixture ¼ part of stronger ammonia is added--poured in very carefully. A bright red ring is found characteristic only of this reaction, and on shaking the foam is bright red also. This is not near so red in urine from tuberculosis, pneumonia, or measles patients. In reply to an inquiry the speaker said these cases were all true typhoid—enlarged spleen, characteristic stools, and temperature and roseola, also the characteristic tongue.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, October 1, 1894.

The President, F. Bazan, M.D., in the Chair.

Dr. L. C. Lane read a paper entitled "Statistics of Mortality from Anesthetics" [published at p. 707]. He then demonstrated Silvester's method of artificial respiration.

Dr. J. O. Hirschfelder asked Dr. Lane if he had had experience with nitrite of amyl in cases of syncope under anesthetics, and if he had had experience with the purified chloroform of Squibb, which is prepared by freezing.

Dr. Lane said he had found nitrite of amyl of great value as a restorative in some cases. He had not used the purified chloroform.

Dr. David Cohn said he had hoped to hear something about the movement as to ether in Germany, which has been so pronounced in the last two years. Formerly only chloroform was used in Germany as an anesthetic, while at the present time many of the prominent professors have adopted ether as the more satisfactory anesthetic.

Dr. R. W. Murphy referred to a case of suspended animation from opium poisoning, in which Marshall Hall's method of artificial respiration was used by Dr. Hirschfelder with the result that the patient revived. She died, however, some hours later.

Dr. C. N. Ellinwood said he had had some experience with the Howard method of artificial respiration particularly. In a case of poisoning by coal-gas he appreciated the value of the violent pressure on the chest wall. Gas escaped from the patient's mouth, so that it was like standing over a gas burner, the odor was so strong. The gas did not come forth when the Silvester method was used. In about fifteen minutes the patient was resuscitated.

Dr. A. W. Perry said the statistics of mortality from the different anesthetics do not properly measure the relative danger. If the evil results following the administration of ether were taken into account, the aggravation of an existing bronchitis or nephritis, the deaths from disturbances due to the vomiting occasioned by it in laparotomy cases, etc., the figures would not speak so decidedly in favor of ether as opposed to chloroform. In New Orleans he was connected with the hospital and used chloroform exclusively, and he never knew of but one death which could be attributed to it.

Dr. Isaac Rivas said his rule for the choice of an anesthetic was simple. In short operations he prefers chloroform, and in operations requiring considerable time he uses ether.

The President said he always had a battery at hand when he apprehended trouble with an anesthetic. He had seen patients come back almost from death as a result of prompt slapping with a wet towel and the application of electricity.

Dr. Lane said he was induced to adopt Billroth's mixture of alcohol, chloroform, and ether, from reading Billroth's published account of 12,000 anesthesias, without a single death. However, he had seen at least one death which could be attributed to it. It is almost inconceivable how small an amount of anesthetic will sometimes cause death. This man was strong and well but addicted to drink. The anesthetic was administered for the purpose of introducing a catheter. He began to fight and scream in a perfect frenzy, and in a moment when his voice was loudest a simple gurgle was heard and he fell back dead. The battery was used, his cheeks were slapped, artificial respiration was performed, but all to no use. Dr. Lane said he never sought more religiously for the cause of death than in the autopsy on this case, but none was found. In a review of the subject by Max Schüller, of Berlin, in his volume of the new German surgery of Billroth and Lücke, he has taken up all the methods of artificial respiration. In an exhaustive series of experiments on the cadaver and in animals he determined with suitable measuring instruments the amount of air introduced by each. He found that the volume of air introduced into the lungs is greater in the Silvester method than with any of the others. The Howard method, which originated in our country, is of particular value from its simplicity and ease of execution in the resuscitation of the drowning. He had witnessed the experiments of Claude Bernard in asphyxiating animals with coal-gas. The carbon monoxide enters into stable combination with the coloring matter of the red blood corpuscles destroying their oxygenating power. The animals could not be resuscitated by artificial respiration, electricity, etc., but by withdrawing a considerable amount of blood, and introducing fresh blood from another animal—transfusion—the animals were brought to life.

Dr. Geo. K. Frink read a paper entitled "The Menopause."

Dr. David Cohn said the doctor spoke of the liver in the menopause. The liver is blamed for much of which it is innocent, and the menopause is also. In this connection the speaker described a case in which there were six attacks of jaundice at the times when menstruation should have taken place. There was complete absence of bile from the feces for some days. The urine was loaded with bile. The patient recovered from each attack in a week or ten days. Emmenagogues were tried, but without effect. Finally, after the sixth attack she fully recovered, and later gave birth to a child. One month after this case was reported, Senator, of Berlin, reported five cases. The jaundice was not hematogenous. It was what might be called icterus vicarious. There was no congestion of the uterus at the menstrual periods, but a congestion of the liver. There is some connection between the liver and the symptoms of the menopause.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

Regular Meeting November 8, 1894.

The President, A. BARKAN, M.D., in the Chair.

Lamellar Cataract.—DR. A. H. VOORHIES presented a very unusual type of lamellar cataract; the anterior two-thirds of the lens being entirely clear, while the posterior third, or maybe less, together with the capsule, were quite opaque, the patient being reduced to the perception of light. In the left eye he had removed the lens, by the usual cataract operation, but there was so much trouble in removing the retained portions of the lens that in the right eye he first needled, transforming it into a traumatic cataract, and 10 days later succeeded in removing the lens *in toto*, without serious difficulty. Dr. Voorhies also exhibited his modification of the Graefe knife. It is somewhat smaller than the Graefe pattern, and the back from the tip, for a distance of two-thirds the length, presents a cutting edge. It seems rather fragile, the speaker admitting that one has already broken and another bent while operating, which accident he attributed to a fault in the manufacture and to an unusually dense cornea.

Quinine Amblyopia.—DR. W. A. MARTIN presented a man, 40 years of age, with a syphilitic history, showing well-marked optic nerve atrophy. His vision was $\frac{6}{9}$ for distance, but the field was very limited. In the right eye he still distinguished colors in the line of vision, but had no perception of color in the left eye. The interesting point of the case was, the man dated the first appearance of his trouble 3 months back, when a sudden blindness of both eyes occurred the day following a dose of 6 or 8 grains of quinine. He recovered almost entirely from the blindness, but for the past 6 or 8 weeks the vision has gradually grown worse. Antisyphilitic treatment has proved of no avail.

Amblyopia following Trauma.—DR. MARTIN also exhibited a case of amblyopia following trauma in a young militiaman. The vision in the right eye was never good, but he could use it to distinguish people on the street. During the railroad strike, he was struck a blow across the eye and the bridge of the nose, since which his vision was reduced to the perception of shadow. He was carefully examined at the Polyclinic by both Dr. W. Hopkins and the speaker, on several occasions; there being no perceptible change in the fundus, excepting that Dr. Hopkins remarked a slight change at the macula. On the evening of the meeting, there had developed a well-marked detachment of the retina, together with a cloudiness of the vitreous. The detachment of the retina followed nearly 3 months after the injury, and manifested itself within a period of 3 days, although the amblyopia shows there must have been a so-called "commotio retinæ" not recognizable with the ophthalmoscope.

Keratoconus.—THE PRESIDENT presented a young man whom he had had under observation 2 years, with gradually increasing keratoconus. At the present time his vision is under $\frac{6}{60}$, and the cornea is almost completely conical and easily depressed in the center. The cornea is very clear, showing no opacities. He quoted from the excellent new work of Dr. Panas as to treatment. The method of bandaging for 18 months or longer he thought would not be tolerated by the free-born American, so the next best method, in his opinion, was that of Tweedy, viz.: puncture with the cautery point, which method he proposed undertaking with the one eye and, if successful, with the other, also, making an iridectomy if necessary.

Gummatous Eye.—THE PRESIDENT also exhibited a case of what he termed a gummatous eye, the whole iris being occupied with small gummata. The process had commenced within a very few weeks of the original infection. The patient had been treated by a specialist on specific troubles, but who had paid no attention to the eye, so that the process was several weeks old when he came under the speaker's treatment. A peculiarity of the case was that, when first observed, the pupil was occupied by a small, black, fungus-like protrusion, it being the everted iris showing the under and pigmented surface. Since the commencement of treatment, the protruding portion has broken away, and can be seen floating about in the anterior chamber. The subconjunctival injection of sublimate solution (1 milligram of the sublimate to 2 drops of water) is being tried, and he will report progress at a subsequent meeting.

SPECIAL CORRESPONDENCE.

LONDON.

The Chelsea Hospital Scandal.—Defence Unions.—The Meeting of the British Medical Association in London, 1895.—Diphtheria and Antitoxin.

The affair of the Chelsea Hospital for Women has attracted a great deal of attention, and has caused much pain and perplexity to those who have at heart the credit and best interests of the medical profession. A report was made by Dr. Louis Parkes, the Medical Officer of Health for the parish of Chelsea, to the vestry, in which he drew attention to the defective sanitary arrangements of the Hospital, to the deficient cubic space in certain wards, and finally to the high post-operation mortality. The Board of Management of the hospital at once practically admitted the justice of his reflections on the sanitary condition of the hospital and immediately undertook the necessary work to satisfy the requirements of Dr. Parkes. The observation as to the high mortality, however, was not so easily disposed of. The medical staff thought, and rightly thought, that the observations affected their professional reputation and honor. A report containing elaborate statistics of all operations in the practice of each one of the staff was prepared and presented to the Board of Management of the hospital, and was laid before a special committee of inquiry, which meanwhile had been appointed. The committee consisted of representatives of the Board of Management, the subscribers, and of the Royal College of Surgeons and of Physicians. This committee presented a report which was of a very damaging character to the management and medical staff of the hospital. It stated that a large number—20 out of 26—of the deaths in the hospital in the period under review, were due to septicemia, and added "that septic temperatures were not infrequent amongst the cases operated on which ultimately recovered. This applies to cases of minor operation as well as to those of more serious character." As it has a bearing upon the general sanitary state of the hospital, it should be noted that "septic temperatures did not prevail in the practice of every member of the staff." The general principles on which the hospital was administered were criticised in an unfavorable sense, so that the lay Board of Management did not escape censure. Finally the committee recommended that a pathologist should be appointed whose duty it would be to make independent examinations of fatal cases and report to the Board of Management direct. The medical staff had already placed their resignations in the hands of the Board, and the Board not only accepted them, but went on to elect a new staff, upon which the old medical officers were very slightly represented. That is to say, the majority of the old medical staff was excluded, and new men appointed. This naturally led to a vigorous protest, based mainly on the ground that the Board of Management, which had been condemned by the Committee of Inquiry, was not a body which ought to have elected a new staff; the subscribers, it was urged, ought to have been called together to receive the resignation of the board and to elect a new one. The consulting members of the staff, whose connection with the hospital was purelv honorary, and who had perhaps never been within its walls, yet thought that in such an emergency they should have been consulted as to the election of the new acting staff, and they also resigned, though one member expressed his willingness to retain his connection with the hospital if the question of the constitution of the new staff was referred to a committee, with medical assessors appointed *ad hoc.* Meanwhile the Vestry of Chelsea had appealed to the Home Secretary to appoint a special Government Commission to inquire into the conduct of the hospital. This politician, after taking a long time to consider, wrote declining to make an inquiry, but did not hesitate to express an opinion without inquiry. A state of things, he said, had been revealed which was most discreditable to the management of the hospital, and especially to the medical staff; he added with an excess of cruelty of innuendo, that he was advised that a criminal prosecution could not be undertaken. A more cowardly kick to men who are down could hardly have been conceived, and it has had the usual effect of acts of this kind, that is, to excite sympathy with the victims, which had not previously existed. Since then a meeting of the subscribers has been held, and after a rather heated discussion, the resignation of the Board of Management, which had been tendered, was not accepted, the Board having a small majority. The whole story is an extremely painful one, but in a letter written from London it was hardly possible to pass it in silence, as the matter has attracted and still attracts much grieved attention, and is likely to inflict an injury on the profession which will not easily be lived down.

The Medical Defence Union, established about ten years ago, to give to its members mutual support in cases of blackmailing and false charges against professional reputation, has passed through a stormy period. The great difficulty has been to arrive at a principle of action on the point whether the Union should use its funds and influence to defend members thought to be unjustly charged by other members. The first difficulty arose in connection with a case in which the then President of the Union was the defendant in an action for libel. Much dissatisfaction was felt at the action of the Council in voting money to defray the legal expenses of the President in this case, and a second society, called the London and Counties Medical Protection Society was formed, and carries on work practically identical with that of the Union. Its President at the present time is Mr. Victor Horsley, who had not long been in office before another difficulty arose; in this instance a legal action was brought between two members of the Union who had been in practice together. One of the Honorary Secretaries refused to entertain the application of one of the parties to the suit. Subsequently the Council took up the case of the other party, and the Honorary Secretary who had refused to interfere in the case at all, resigned in dudgeon, and has started yet a third Defence Association. The legal proceedings dragged on for months, and have only recently come to an end. Early in October meetings of the Union were held in London, Manchester, Birmingham, and Bristol, and at each place votes of confidence in the Council were adopted. The Union therefore survives, but it is now proposed that the British Medical Association should take up some of the work of the Union. The Union was founded originally to defend its members against blackmailing, but very soon it became involved in attempts to put the law against irregular practice in action. It is now proposed that in some way or other the B. M. A. should either make a special contribution to defray the cost of this part of the work or should undertake it altogether. It is complained that the law as it stands is too weak, and Parliament is to be asked to strengthen it, but it is certain that even as it is the law is not enforced. In France the law, which was always stringent, has recently been amended and made stronger still; moreover it is enforced. In the German Empire, also, not only are the laws strong, but they are enforced by the police. The patent medicine-monger, for instance, is liable to find the town in which he is operating placarded with notices informing the public of the composition of his cure-all, warning as to its dangers, and stating the ordinary retail price of the drugs of which it is made.

As already mentioned, the annual meeting of the British Medical Association will be held next August in London. A meeting of the General Committee was held on October 31st, and was attended by over 700 members of the Metropolitan Counties Branch of the Association. The chair was occupied by Dr. Russell Reynolds, President of the Royal College of Physicians. Some preliminary steps have already been taken and the use of the laboratories at the Royal Colleges of Physicians and Surgeons, on the Thames embankment, has been secured. This building is spacious, and contains an excellent lecture theater, but it is certain that it will not provide sufficient accommodation. Exeter Hall is near at hand, but other rooms will be required for some of the Sections, and it is not easy to see where these are to be found. The difficulty will no doubt be overcome, and the laboratories have the great advantage of being in the very center of London, near the Underground Railway, and the Strand, which is one of the great arteries of omnibus traffic. It has been arranged to have fifteen sections, an excessive number. The Address on Medicine will be given by Sir William Broadbent; on Surgery, by Mr. Arthur Durham, of Guy's Hospital; and on Physiology, by Prof. E. A. Schäfer, F. R. S., Professor of Physiology, in University College. A Foreign Reception Committee, with Mr. Ernest Hart, as Chairman, has been appointed, and it is hoped that the invitation to foreign colleagues to attend will be accepted extensively. The present estimate of the number of members and visitors likely to assemble in London at the beginning of next August, is 5,000.

The epidemic of diphtheria in London, this autumn, though not much more than usually severe, has attracted an unusual amount of public attention, owing perhaps, to the papers having been full of reports from the Buda-pest Congress, about the success with which the antitoxin-serum has been used in Berlin and Paris. It is hoped that the British Institute of Preventive Medicine, which has at present very inadequate laboratory accommodations, as the buildings of the Institute have not yet been commenced, may shortly be able to supply the serum, and some horses are already in process of preparation. Meanwhile the serum has to be obtained at an extravagant price from Germany, and the supply is inadequate. London has not yet followed the example of New York in organizing a special service for the bacteriological diagnosis of diphtheria, and as the authority which deals with the prevention of disease is the County Council of London, and that which treats the cases after they have arisen, is the Metropolitan Asylums Board, a much older body, and as the County Council is very jealous of its dignity, much more delay is likely to take place. Meanwhile the infectious hospitals are full.

LONDON, November 3, 1894.

CORRESPONDENCE.

Serum Therapy in Diphtheria—Toxines in Sarcomas.

⁂ The following extracts from a letter, received from Dr. G. L. Simmons and dated at New York, are of several interest.

In New York just now the absorbing questions appear to be connected with serum therapy in diphtheria and the use of toxines in the treatment of sarcomas. Without presuming to offer an opinion upon the benefits to be derived from immunized serum, where time and long experience are essential factors, I will say that I am surprised at the mortality of diphtheria in the French hospitals, as given by the advocates of the serum practice. For four consecutive years they state an average of 51.71 per cent. of deaths, while at the Trousseau hospital for four months the mortality was 60 per cent. I think we have never had in California an epidemic of diphtheria in which our rate of mortality exceeded 24.5 per cent. or the figures now presented as a grand result of serum therapy. The use of toxine in the treatment of soft cancers has, in some cases, been attended with the most encouraging results. Last week I attended a meeting of the New York Academy of Medicine, where Dr. Wm. B. Coley read a valuable paper, entitled "Further Observations on the Treatment of Malignant Tumors with the Toxines of Erysipelas and Bacillus Prodigiosus." He reported over thirty cases under treatment and observation, in several instances lasting over a year, and presented to the large audience five cases of apparent recoveries from sarcomatous growths in various parts of the body. I examined these cases as carefully as I could, and, after learning their histories, confess I was surprised at the results obtained. Dr. McBurney, who had been appointed to speak upon the subject, said the cases were encouraging, and he urged further experimentation in the same direction.

REVIEWS AND NOTICES.

THE MEDICAL REVIEW VISITING LIST PERPETUAL. St. Louis, J. H. Chambers & Co. This List is neatly bound in red, with flexible cover and flap, and in general make up follows the usual style. The editor states that the general information here presented is such as will be most helpful in the every day or occasional emergencies that confront the practitioner. A table of doses is included, but on looking over it we observe that two proprietary preparations are mentioned, one of which is certainly out of place, as it is not intended for internal use. This, with the advertising page accompanying the list, duly sets forth the merits of the preparations in question, with others.

PHYSICIAN'S VISITING LIST for 1895, 44th year, Philadelphia, P. Blakiston, Son & Co. This old and familiar favorite remains unchanged in form. The mis cellaneous information accompanying it has been revised and additions made, where practicable. In the dose table, the drugs and doses have been carefully revised and such additions made as bring it completely up to date. This also applies to a list of new remedies in which we find salicylate of mercury and gallanol, with other less familiar agents. Poisons and antidotes, disinfectants and some useful tables are also included. Taking it all together, the Physician's Visiting List remains without a superior, and there are none that equal it in neatness and general mechanical excellence.

ESSENTIALS OF THE DISEASES OF THE EAR, ARRANGED IN THE FORM OF QUESTIONS AND ANSWERS. PREPARED ESPECIALLY FOR STUDENTS OF MEDICINE AND POST-GRADUATE STUDENTS. By E. B. Gleason, S.B., M.D., Clinical Professor of Otology, Medico-Chirurgical College, Philadelphia; Surgeon-in-Charge of the Nose, Throat and Ear Department of the Northern Dispensary, Philadelphia. Saunders' Question Compends, No. 24. Philadelphia: W. B. Saunders.; pp. 148. Price, $1.00.

This little work is especially designed for physicians desiring post-graduate study of otology, and to supplement the brief courses of lectures on this subject. Like the other compends of this series, it contains a great amount of information in small compass. Nearly 150 pages are devoted to concise and clear questions and answers on the anatomy of the ear, and the various ear diseases and their treatment. For those having limited time for the study of this branch, this small work can be highly recommended, as the information is in a very accessible form.

ESSENTIALS OF MINOR SURGERY, BANDAGING, AND VENEREAL DISEASES; ARRANGED IN THE FORM OF QUESTIONS AND ANSWERS; PREPARED ESPECIALLY FOR STUDENTS OF MEDICINE. By Edward Martin, A.M., M.D., Clinical Professor of Genito-urinary Diseases; Instructor in Operative Surgery, and Lecturer on Minor Surgery, University of Pennsylvania, etc. Second edition, revised and enlarged; 78 illustrations. Saunders' Question Compends, No. 12. Philadelphia, W. B. Saunders; pp. 166. Price, $1.00.

The second edition of this popular work has been thoroughly revised and brought up to the present standard of surgical practice. A large number of the illustrations have been redrawn and engraved, and an entirely new set of bandaging cuts, taken from the "American Text-book of Surgery," have been inserted. The book will be found specially useful to those beginning practice and to those engaged in hospital or clinical work. A great deal of information, gathered from many different sources, is presented in a concise form, so that the various practical points of minor surgery and bandaging may be easily and quickly referred to.

SYLLABUS OF LECTURES ON HUMAN EMBRYOLOGY: AN INTRODUCTION TO THE STUDY OF OBSTETRICS AND GYNECOLOGY. FOR MEDICAL STUDENTS AND PRACTITIONERS. WITH A GLOSSARY OF EMBRYOLOGICAL TERMS. By Walter Porter Manton, M.D., Professor of Clinical Gynecology and Lecturer on Obstetrics in the Detroit College of Medicine. Illustrated with 70 outline drawings and photo-engravings; 12-mo, cloth, 126 pages, interleaved for adding notes and other illustrations; $1.25 net. Philadelphia: The F. A. Davis Co., Publishers.

This work is designed particularly for use in the lecture-room. It is profusely illustrated with diagrams and cuts, and interleaved with blank pages for the purpose of making notes. The subject matter is arranged to a great extent in outline, and yet explicit enough to enable the student to grasp the main points easily and quickly. The plan of the book includes the anatomy of the sexual organs, the physiology of reproduction, the development of the fetus, and finally considerations concerning the condition of the mother during pregnancy and of the child at birth. A section on practical laboratory work is added, giving valuable information on the conduct of experiments in developing egg germs. Embryology is attracting increased attention. The recent advances in the subject have thrown much light on the structure of the human body, and accordingly it is becoming a valuable adjunct, not only of the study of obstetrics and gynecology, but also of anatomy. Many of the dry facts of the latter become interesting and intelligible when viewed through the light of embryology.

A PRACTICAL MANUAL OF MENTAL MEDICINE. By Dr. E. Regis, formerly Chief of Clinic of Mental Diseases, Faculty of Medicine, Paris; formerly Assistant Physician of the Sante-Anne Asylum, Physician of the Maison de Sante Castel A' Andorte, Laureate of the Medico-Physiological Society of the faculty of Medicine of Paris, Professor of Mental Diseases, Faculty of Medicine, Bordeaux, with a preface by M. J. Ball, Clinical Professor of Mental Diseases, Faculty of Medicine, Paris; a work crowned by the Faculty of Medicine, Paris. Chateauvillard prize, 1886. Second edition, thoroughly revised and enlarged, re-written, authorized translation by H. M. Bannister, A.M., M.D., late senior Assistant Physician, Illinois Eastern Hospital for the Insane. With introduction by the author. Utica: Press of *American Journal of Insanity*. Pages xvi—692.

This book is, as mentioned by the author in his preface to the translation, the first instance of a work, treating of mental diseases, which, written by an alienist and translated by an alienist, has been printed and bound by the insane under the direction of an alienist. The treatise is divided into two parts, the first of which begins with a short outline of the history of the care of the insane, followed by a definition of insanity and an account of the etiology of mental diseases, After giving a resume of the course, duration, prognosis, and pathological anatomy of the diseases in question, the author takes up the general symptoms and classification of insanity. After giving classifications by Baillarger, Magnan, Hack Tuke, Krafft, Ebing, etc., Prof. Regis adds his own subdivisions of the psychoses. He divides them into functional and constitutional. The first group consists of symptomatic or generalized and partial or essential insanities. The symptomatic comprise forms of mania, melancholia, and *folie à deux* (circular insanity), while only one form of partial psychosis is mentioned, chronic paranoia. The term, partial insanity, is not viewed with favor by modern authors, as it is highly improbable that there can be such a state. The constitutional psychoses are subdivided into: (1) Disharmonies—defect of balance, originality, excentricity. (2) Neurasthenias—fixed ideas, impulsions, aboulias. (3) Phrenasthenias—delusional reasoning, instinctive phrenasthenias. (4) Monstrosities—imbecility, idiocy, cretinism. (5) Dementia. After the classification the author enters upon the subject of special pathology, beginning with the typical forms of functional and constitutional insanities and closing with mental derangements accompanying physiological and pathological conditions, such as hebephrenia (insanity of puberty), insanity of diabetes, cancer, psychoses in epilepsy, Basedow's disease, etc. He finishes the subject of special pathology with a consideration of the toxic insanities, alcohol, lead, morphine, etc. The second part of the book treats of the application of mental pathology to practice: the taking of the family and personal history, the examination of the patient and the preventive and curative treatment of insanity. The last chapter considers the relationship of insanity to legal medicine: the penal responsibility of the insane, crimes and misdemeanors of the insane, and medico-legal examinations. The author is quite pronounced on the subject of the origin of many psychoses from auto-intoxication. He mentions the good effects obtained by washing out the stomach in melancholiacs, not only upon the sitiophobia (refusal of food), but upon the melancholia itself. He also speaks of the results of experiments on animals by Dr. Chevalier-Lavaure, who found, that while an average of 25 c.cm. of normal daily urine will kill an animal, 60 c.cm. of maniacal daily urine is required to produce the same effect. This would lead one to think, that in the insane, poisonous substances circulate in the blood, which in the well person are excreted by the kidneys, The question would be, however, whether the retention of normal poisons in the blood is the cause or the effect of the psychosis. The author, in speaking of puerperal insanity, says the suppression of the lochia, or the milk, is one of the necessary causes of the insanity. It would be more apt to be a symptom and a result. He also says the clinical form taken by puerperal insanity is always mania or melancholia. While this is the rule, an acute form of paranoia is frequently met with. From a didactic standpoint, Prof. Regis' work is very good. It is systematically arranged, concise, and quotes many interesting and significant facts in elucidation of the subject under consideration. In connection with the facts relating to the mechanical work, it may be stated that the book is substantially bound, and the print clear.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held November 12th, the following were granted certificates to practise medicine in this State:

Robert Foster Andrews, San Francisco; Dartmouth Med. Coll., N. H. Nov. 11,'57.
Edwin Murray Arenschield, Monrovia; Med. Dept. State Univ. of Iowa, March 7,'83.
James R. Arneill, Los Angeles; Med. Dept. Univ. of Mich., June 28,'94.
George W. Carpenter, Riverside; Med. Dept. Univ. of Mich., March 30,'53.
Jere Lawrence Crook, Sacramento; Med. Dept. Vanderbilt Univ., Tenn., March 26,'94.
Robt. H. Curtis, San Francisco; Kentucky School of Medicine, Ky., June 21,'94.
John Ermerius, Los Angeles; Examining Boards North and South Holland, Aug. 12 and 28, '62.
B. F. Fleming, San Francisco; Med. Dept. Univ. California, Dec. 14,'93.
Morris J. Gates, Oakland; Kentucky School of Medicine, Ky., June 21,'94.
Chas. B. H. Hanvey, Greenville; Med. Dept. McGill Univ., Canada, March 31,'83.
Jacob Horsch, Los Angeles, Univ. of Wurzberg, Germany, Jan. 30,'91.
W. R. Patton, Lindsay; Med. Coll. Virginia, April 3,'94.
Oswald F. Rudolph, Los Angeles; Cincinnati Coll. Medicine and Surgery. Feb. 26,'85.
Frank M. Rumbold, San Francisco; St. Louis Med Coll , Mo., March 5,'84.
George Charles Somers, Pasadena; Rush Med. Coll , Ill., Feb. 24,'80.
R. L. Sutherland (2d certificate), San Francisco; Med. Dept. Univ. of Cal., Dec. 15,'92.
Masajiro Toki, San Francisco; Saisei Med. Coll., Japan, March 31,'83.
John V. Tormey, Pinole; Bellevue Hosp. Med. Coll., N. Y., March 27,'93.
Agnes Walker, San Rafael; Cooper Med. Coll., Cal., Dec. 7,'93.
Henry Lee Wood, Napa; Kansas City Med. Coll., Mo., March 22,'94.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Div. Pacific), from October 20, to to November 20, 1894.

So much of the Special Order as directs Captain Ogden Rafferty, assistant surgeon, to report to the commanding officer Presidio of San Francisco, Cal., for duty, is revoked.

Leave of absence for six months, on surgeon's certificate of disability, is granted Major Clarence Ewen, surgeon.

ITEMS.

Dr. S. Iglick has removed from Pike City to Alleghany, Sierra county, Cal.

Dr. A. Huffaker has removed from Brownsville, Cal., to San Leandro, Cal.

Dr. Albert Abrams has resumed practice at 431 Geary street. San Francisco. Hours, 1 to 3:30 P. M.

Dr. F. W. Birdsall has removed from San Francisco to Sacramento, Cal., and has opened an office at 718 J street.

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AMERICAN MEDICAL ASSOCIATION HOTEL AND RAILROAD RATES—ITINERARY OF EXCURSIONS, WITH COST OF SAME.

Hotel Rates.—The following hotels, centrally situated and convenient to the place of meeting, have quoted special rates, for members and their families, which will apply during the entire stay of the guests, who should, upon registering, signify that they are in attendance upon the meeting of the Association. The rates quoted are for one person, the variation depending upon the size, situation, and appurtenances of the rooms, as single, *en suite*, with private bath, etc.; special arrangements will be made for families, or parties, on timely notice. Some of the hotels entertain upon the American plan (room and board) only, some upon the European plan (room without board) only, and some upon either plan.

Palace Hotel (headquarters)	American plan, $3.50 to $5.50 a day. European plan, $1. 50 to $3.50 a day.
Grand Hotel	Connected with the Palace by a glass enclosed bridge, across New Montgomery street, European plan only, $1 to $2 a day.
Baldwin Hotel	American plan, $3.50 to $5 a day. European plan, $1 to $3 a day.
California Hotel	American plan, $3.50 and up a day. European plan, $1.50 and up a day.
Lick House	American plan, $2.50 and up a day. European plan, $1 and up a day.
Russ House	American plan, $2.00 to $3.50 a day. European plan, 50c to $2 a day.
Occidental Hotel	American plan only, $2.50 and up a day.
Hotel Pleasanton	American plan only, $2.50 to $5 a day.

Railroad Rates—Midwinter Fair Rates Positively Assured.—In the latter part of March a meeting of the railroads forming the Transcontinental Association was held, and an agreement reached extending the sale of tickets under what are known as "Midwinter Fair excursion rates," and which are referred to as such in Mr. Goodman's letters (*vide* MEDICAL TIMES, vol. viii, p. 213), until June 30th. The following telegram is self-explanatory:

> OCCIDENTAL MEDICAL TIMES, *Sacramento, Cal.*—Special rate $65.50, San Francisco and return, on account Midwinter Fair, will be continued till June 30th, from Missouri river points, Sioux City to Kansas City, inclusive.
>
> T. H. GOODMAN, Gen. Pass. Agt. S. P. Co.

This finally disposes of the vexed question of reduced rates, which has been giving the Committee of Arrangements no little anxiety. Should lower rates be in force, visitors will have the benefit of them, but this, which is virtually a one-fare rate, is now assured.

Itinerary of Excursions, with Cost of Same.—The following itinerary is published for the guidance of eastern visitors. It will be found to cover all points of interest in the State. We shall be pleased to furnish additional information or to answer inquiries on these points:

Mount Hamilton, Santa Cruz, and Monterey:

Leave San Francisco	Monday,	8:15 a. m.
Arrive Palo Alto	Monday,	9:36 a. m.
Visit Leland Stanford, Jr., University.		
Leave Palo Alto	Monday,	12:03 p. m.
Arrive San José	Monday,	12:41 p. m.
Three hours in San José.		
Leave San José	Monday,	3:48 p. m.
Arrive Del Monte	Monday,	6:15 p. m.

Stay at Del Monte can be prolonged indefinitely, but at least two days should be taken in which to see the objects of interest in the neighborhood. On the day following arrival, we would suggest that the famous seventeen mile drive be taken. This leads through Pacific Grove, round Cypress Point, along Pebble Beach, and back to the hotel, and is acknowledged to be one of the finest drives of its length in the country. On Wednesday, the old Mission Churches in the neighborhood and other objects of interest should be visited, and time can be taken for a dip in the surf.

Leave Del Monte	Friday,	6:53 a. m.
Arrive Pajaro	Friday,	7:38 a. m.
Leave Pajaro	Friday,	7:50 a. m.
Arrive Santa Cruz	Friday,	9:15 a. m.

On Friday morning we would suggest a drive along the beach at Santa Cruz, and in the afternoon a visit could be made to the Big Tree Grove. The drive up the cañon is much more interesting than the same trip by rail, and there is ample time to visit the big trees and return before dark.

Leave Santa Cruz (via Narrow Gauge)	Saturday,	8:00 a. m.
Arrive San José (via Narrow Gauge)	Saturday,	9:50 a. m.

Visitors to the Lick Observatory are allowed to use the instruments on *Saturday night only*, and the trip to Monterey and Santa Cruz should be arranged so as to arrive at San José on the return Saturday morning. This could be done by leaving San Francisco a day or two later than quoted above, but in order to examine the instruments at the Observatory, the trip there would have to be made Saturday afternoon on following schedule:

Leave San José (by stage)	Saturday, about	12:30 p. m.
Arrive Smith Creek Hotel	Saturday, about	5:00 p. m.
Dinner at Smith Creek Hotel.		
Leave Smith Creek Hotel	Saturday, about	6:00 p. m.
Arrive Observatory	Saturday, about	6:45 p. m.
Leave Observatory	Saturday, about	9:30 p. m.

Return can be made to San José the same night, arriving there at 1:00 a. m. Sunday morning; but as this makes a rather tedious trip, we would suggest that a stay be made over night at Smith Creek Hotel, taking the road down the mountain in the early morning. If the morning happens to be clear, the ride is a very exhilarating one.

Leave San José	Sunday,	11:40 a. m.
Arrive San Francisco	Sunday,	1:45 p. m.
Or leave San José	Monday,	8:00 a. m.
Arrive San Francisco	Monday,	9:47 a. m.

Holders of excursion tickets to San Francisco and return, sold per account Midwinter Fair, either from points on the line of the Southern Pacific Company or from eastern points, can purchase an excursion ticket, covering the trip to Monterey and return, via Santa Cruz, for $4.90. Such a ticket bears the same limit as the original excursion ticket held by the passenger; but in no case more than thirty days from the date of sale, but allows stopovers at any point within that time. The trip from San José to the Lick Observatory and return is $5.00. The hotel charges at Monterey, Santa Cruz, and Smith Creek, will naturally vary with the accommodations, ranging from $3.00 a day upward.

Big Trees and the Yosemite:

Leave San Francisco	Monday;	4:30 p. m.
Arrive Berenda	Monday,	10:39 p. m.
Leave Berenda	Tuesday, about	5:45 a. m.
Arrive Raymond	Tuesday,	7:05 a. m.

During the Yosemite season, a through Pullman sleeper is run between San Francisco and Raymond, without change.

Leave Raymond (by stage)	Tuesday,	8:00 a. m.
Arrive Wawona (by stage)	Tuesday,	6:00 p. m.

Stay over night at Wawona.

Leave Wawona	Wednesday,	6:00 a. m.
Arrive Yosemite	Wednesday,	Noon.

It is hardly possible to see the wonders of Yosemite inside, at least, three or four days, and the stay can be profitably prolonged to a couple of weeks.

Leave Yosemite (by stage)	Monday,	1:00 p. m.
Arrive Wawona (by stage)	Monday,	6:00 p. m.

Stay over night at Wawona.

Leave Wawona	Tuesday,	7:00 a. m.

Side trip is made from Wawona to the Mariposa Big Trees, staying long enough to get a good view of the latter.

Arrive Raymond	6:00 p. m.
Leave Raymond (by rail)	7:00 p. m.
Arrive San Francisco	5:45 p. m.

The round-trip rate from San Francisco to Yosemite and return, including Pullman fare, is $50.00. Cost of a double berth in sleeper between San Francisco and Raymond in each direction is $1.50. Holders of excursion tickets from the East to Los Angeles and return can purchase, at Berenda, a ticket to the Yosemite Valley and return for $45.00. Those holding excursion tickets to San Francisco and return can use them as far as Lathrop, and at that point purchase a ticket to the Valley and return for $47.00. The cost of accommodations in the Valley ranges from $3.00 a day up. The services of a guide can be secured at rate of about $5.00 a day.

Lake Tahoe and Return:

Leave San Francisco	Monday,	6:00 p. m.
Arrive Truckee	Tuesday,	6:40 a. m.
Leave Truckee (by stage)	Tuesday,	8:00 a. m.
Arrive Tahoe City	Tuesday,	10:30 a. m.

There are several resorts at Lake Tahoe, the principal one being the Tallac House. The rates at those resorts range from $2.50 a day upward. There are so many points of interest at the Lake, and one's time can be so pleasantly spent, that the stay can be indefinitely prolonged. The return trip can be made direct through Truckee, leaving Lake Tahoe in the evening and arriving at San Francisco the next morning, or the return can be made through Carson and Reno. The latter trip will give an opportunity of inspecting the famous mines at Virginia City, schedule being about as follows:

Leave Tahoe City	Monday,	11:30 a. m.
Leave Glenbrook	Monday,	1:00 p. m.
Arrive Carson	Monday, about	3:00 p. m.

It is necessary to remain here about 2½ hours, which will give time to visit the Penitentiary, in the quarries of which are found the mammoth footprints of prehistoric man, which will prove of interest to those of a scientific turn of mind.

Leave Carson	Monday,	5:10 p. m.
Arrive Virginia City	Monday,	7:00 p. m.
Tuesday morning at Virginia City.		
Leave Virginia	Tuesday,	5:20 p. m.
Arrive Reno	Tuesday,	8:05 p. m.
Leave Reno	Tuesday,	8:25 p. m.
Arrive San Francisco	Wednesday,	9:45 a. m.

Excursion tickets are on sale at San Francisco to Lake Tahoe and return, both ways via Truckee, at $16.00; going via Truckee, returning via Reno, $20.00. Tickets are also on sale, including board at the hotels at rate of about $2.50 a day.

Sacramento.—This city, the Capital of the State, in addition to the State Capitol, with its picturesque Park, and the E. B. Crocker Art Gallery, is the location of "Sutter's Fort," now being restored by the State. This fort, built by General Sutter in 1839, is interesting, as being the first American settlement in California, and for many years the haven for emigrant trains that crossed the plains. Sacramento is distant from San Francisco 98 miles, and can be seen when going to or returning from Lake Tahoe and the Sierras, as follows:

Leave San Francisco	7:00 a. m.
Arrive Sacramento	11:15 a. m.
Leave Sacramento	10:00 p. m.
Arrive Truckee	6.40 a. m.
Or leave Truckee	7:00 p. m., or 10:45 p. m.
Arrive Sacramento	2:40 a. m., or 5:45 a. m.
Leave Sacramento	3:00 p. m.
Arrive San Francisco	7:45 p. m.

To Lake County Resorts and Return.—There are numerous springs and summer resorts located in Lake county, reached through Calistoga. The principal attraction in that territory, however, is the Geysers, located in Sonoma county. The trip can be made as follows:

Leave San Francisco	Monday,	7:30 a. m.
Arrive Calistoga	Monday,	10:50 a. m.
Leave Calistoga	Monday,	11:30 a. m.
Arrive Geysers	Monday,	5:30 p. m.
Returning, leave Geysers	Tuesday,	8:00 a. m.
Arrive Calistoga	Tuesday,	1.30 p. m.
Leave Calistoga	Tuesday,	3:05 p. m.
Arrive San Francisco	Tuesday,	6:15 p. m.

The round-trip rate from San Francisco is $8.50. The trip can be made to the Geysers, going via Calistoga and returning via Cloverdale, round-trip rate being $11.00.

To Southern California:

Leave San Francisco	Monday, 5:00 p. m.
Arrive Fresno	Tuesday, 1:10 a. m.

Remain in sleeper until morning, and spend Tuesday at Fresno, inspecting the vineyards in the neighborhood, some of the largest in the State being located at that point.

Leave Fresno	Tuesday, 5:50 p. m.
Arrive Bakersfield	Tuesday, 10:05 p. m.

The system of irrigating is carried on to a large extent at Bakersfield, and this place affords an excellent opportunity of studying the methods in vogue in California. The Kern County Land Company conduct the system on an immense scale, the headquarters being at Bakersfield. A day can be very profitably spent in this manner.

Leave Bakersfield	Wednesday, 10:20 p. m.
Arrive Los Angeles	Thursday, 7:30 a. m.

Thursday, Friday, and Saturday at Los Angeles. On one of these days make a trip to Santa Monica and Port Los Angeles, where is located one of the longest wharfs in America. The beach at Santa Monica is unrivalled for bathing facilities. The following is the itinerary:

Leave Los Angeles	9:15 a. m.
Arrive at Santa Monica	10:22 p. m.
Leave Santa Monica	3:30 p. m.
Arrive Los Angeles	4:35 p. m.

A day can be profitably spent in Pasadena, as follows:

Leave Los Angeles	9:00 a. m.
Arrive Pasadena	9:30 a. m.

Take a drive to Sierra Madre Villa, going through East San Gabriel, where is located an interesting old Mission church, and returning through the ranch of L. J. Rose, and Baldwin's Santa Anita ranch.

Leave Pasadena	6:05 p. m.
Arrive at Los Angeles	6:30 p. m.

We would suggest that Sunday be spent at Riverside, going there Saturday afternoon, as follows:

Leave Los Angeles (via Colton)	4:30 p. m.
Arrive Riverside	6:55 p. m.

Riverside bears about the same relation to the orange industry in California as Fresno does to the raisin. Magnolia Avenue is acknowledged to be one of the finest streets in the world. The avenue is lined with orange groves, and makes one of the prettiest drives in California. From Riverside the trip to San Diego can be made as follows:

Leave Riverside	Monday, 7:55 a. m.
Arrive Orange	Monday, 9.15 a. m.
Leave Orange	Monday, 9:23 a. m.
Arrive San Diego	Monday, 12:50 p. m.
Arrive Coronado	Monday, 1:30 p. m.
Tuesday and Wednesday at Coronado.	
Leave Coronado	Thursday, 6:30 a. m.
Arrive San Diego	Thursday, 8:00 a. m.
Leave San Diego	Thursday, 8:40 a. m.
Arrive Los Angeles	Thursday, 1:15 p. m.

Before returning to the northern part of the State, Santa Barbara should be visited; and probably some of the party would like to continue the journey over the rail and stage route along the coast, there being no through line in that direction. The following is the itinerary:

Leave Los Angeles	Thursday, 2:00 p. m.
Arrive Santa Barbara	Thursday, 7:05 p. m.
Friday, Saturday, and Sunday at Santa Barbara.	
Leave Santa Barbara	Monday, 8:00 a. m.
Arrive Los Olivos	Monday, 4:30 p. m.
Stay over night at Los Olivos.	
Leave Los Olivos (via rail)	Tuesday, 7:40 a. m.
Arrive San Luis Obispo	Tuesday, 11:30 a. m.
Tuesday afternoon at San Luis Obispo.	
Leave San Luis Obispo	Wednesday, 7:00 a. m.
Arrive Santa Margarita (via stage)	Wednesday, 9:00 a. m.
Leave Santa Margarita (via rail)	Wednesday, 9:30 a. m.
Arrive San Francisco	Wednesday, 6:26 p. m.

If return is made from Santa Barbara via the San Joaquin Valley, the itinerary would be as follows:

Leave Santa Barbara	Monday, 9:06 a. m.
Arrive Saugus	Monday, 12:15 p. m.
Leave Saugus	Monday, 3:58 p. m.
Arrive San Francisco	Tuesday, 10:45 a. m.

Holders of Midwinter Fair excursion tickets can purchase a round-trip ticket to Los Angeles and return for $18.00. At Los Angeles, we have special excursion rates to all resorts in the neighborhood. If the passenger desires to return by way of Santa Barbara, the agent at Los Angeles will lift his ticket reading to San Francisco, and on payment of $5.00 furnish him a ticket reading from Los Angeles to Santa Barbara and Santa Margarita to San Francisco. Tickets will have to be got for the intervening rail and stage lines, the rate from Santa Barbara to Santa Margarita being $7.30. Persons returning over this route can make side trips to Monterey and Santa Cruz, stopping at San José, to make the Mount Hamilton trip, itinerary for which would be about as outlined.

Paso Robles.—One of the most famous sanitariums on the Pacific coast is located at Paso Robles, on the line of the Coast Division of the Southern Pacific Company. There is a magnificent hotel located here, and the facilities for various kinds of baths are unexcelled. Every physician visiting the Pacific coast should make a special point of visiting this resort. It can be done in connection with the Monterey and Santa Cruz trip, or in connection with the journey from Santa Margarita to San Francisco, along the Coast route. There is one through train a day, in each direction, between Paso Robles and San Francisco, as follows:

Leave San Francisco	8:15 a. m.
Arrive Paso Robles	4:19 p. m.
Returning, leave Paso Robles	10:12 a. m.
Arrive San Francisco	6:26 p. m.

Connection is made at Castroville with the morning train from Monterey, and at Pajaro with the morning train from Santa Cruz. It will be noted that the train from Santa Margarita leaves that point 9:30 a. m., arriving Paso Robles 10:12 a. m. A stop-over of a day or two may be made at this point, and the trip resumed to San Francisco. A special reduced rate will be made at this hotel to members of the American Medical Association.

Up the Sacramento Valley.—The trip up the Sacramento Valley is made at night, the train arriving at the scenic part of the road the following morning. A favorite resort on this route is the Tavern of Castle Crags, a modern caravansary, modeled on the lines of the old-time inn. This would be an excellent place to sojourn for a day or two, taking in the sights in the neighborhood of Mount Shasta.

Arrive Castle Crags	Tuesday,	8:56 a. m.
Leave Castle Crags	Thursday,	8:56 a. m.
Arrive Portland	Friday,	8:20 a. m.
Spend a day at Portland.		
Leave Portland	Friday,	5:00 p. m.
Arrive Tacoma	Friday,	10:40 p. m.

The return trip is as follows:

Leave Tacoma	Monday,	11:00 a. m.
Arrive Portland	Monday,	5:40 p. m.
Leave Portland	Monday,	6:15 p. m.
Arrive San Francisco	Wednesday,	10:45 a. m.

To Alaska.—The pleasantest way to make the tour to Alaska is to go by rail to Puget Sound, and connect with the Alaska steamships at Tacoma. This varies the monotony of a long sea voyage, and the scenery along the Shasta route and around Puget Sound is such as to make the trip exceedingly pleasant. The Alaska steamers leave Tacoma 4:00 a. m., Seattle 9:00 a. m., and Victoria in the afternoon, of the following days: June 7, 12, 22, 27, July 8, 12, 22, 27, August 6, 11, 21, 26, September 10. Passengers intending to take the steamer at Tacoma should arrive there early enough to go on board the evening previous to the sailing, as steamers leave at 4:00 a. m. Excursion tickets from San Francisco to Alaska and return, including passage by rail to Puget Sound, are sold at rate of $140. Tickets from Seattle or Tacoma can be purchased for $100. The itinerary for the trip, San Francisco to Puget Sound, is as follows:

Leave San Francisco	Monday,	7:00 p. m.

San Francisco and North Pacific Railway—Excursion Rate.—Dr. R. H. Plummer, the Chairman of the Committee of Arrangements, has received a letter from the General Passenger Agent of the S. F. & N. P. R. R. offering a substantial reduction in rates for the visitors, and also for those attending the meeting. He says: "Our road runs through Marin, Sonoma, and Mendocino counties. It is considered one of the most delightful and picturesque rides in California. There is no territory in the world of the same size containing a greater diversity of mineral springs, for here all the principal waters of Europe are duplicated. To afford members of the Convention an opportunity to enjoy the beautiful scenery of this section, as well as to realize its agricultural resources, we will name a rate of *one fare* for the *round trip* over any portion of our line. As many of the springs and resorts are off the main line, it will be well for members to make up parties, when we will arrange, not only for railroad transportation, but also for staging, hotel accommodation, etc., for any number of days and for any number of persons, and will furnish the exact figures before hand." This very liberal offer will well repay any of the visitors to accept, as the scenery in the coast counties through which the road passes is very fine.

REPORT OF COMMITTEE ON REVISION OF CONSTITUTION, BY-LAWS AND CODE OF ETHICS OF THE AMERICAN MEDICAL ASSOCIATION.

History.

In May, 1846, a medical convention was held in the city of New York to consider measures for the elevation of the medical profession, in all its constituent elements, and for the promotion of its organic unity. After much discussion it declared that a National organization of every State and interest was demanded. Committees were appointed to draft a Constitution, By-Laws and a Code of Ethics, and to report at a meeting to be held the following year. Accordingly, in May, 1847, representatives of the profession of the United States met in Philadelphia, heard and discussed reports of committees, and adopted a Code of Ethics, a Constitution and By-Laws, which, with slight alterations, have continued to direct the organized movements of the profession till now. In compliance with the instruction of the Association in June, 1892, the following Constitution and By-Laws are formulated for the purpose of promoting the best activity of a general medical organization of the profession in North America:

Constitution.

Name.—This organization shall be known as The American Medical Association.

Members.—Membership shall be limited to members of the several affiliated State medical societies[1] recognized thereby or represented therein. As membership in these societies is open to all reputable practitioners in each State, the membership in the American Medical Association is open to all reputable physicians in North America. All persons now members of the Association shall continue such so long as they remain in good standing in their State society, and pay their annual dues. If they desire to participate in any annual meeting, they shall present to the Committee of Arrangements of said meeting a certificate from the officers of their State or local society to the effect that their standing is good, and one from the Treasurer of the Association showing that all dues are fully paid. To all presenting such certificates, the Committee of Arrangements shall issue the credentials necessary for active participation in the annual meeting. Any member of a recognized State or local medical society may become a member of the Association by presenting to the Committee of Arrangements at any annual meeting a certificate from the officers of his society showing that he is in good standing therein, and a certificate from the Treasurer of this Association showing that he has paid the annual dues. All members of the recognized State or local medical societies who are unable to attend the annual meeting may become members of the Association by sending to its Treasurer, at any time, a certificate, from the officers of his society, of his good standing, and remitting the annual dues. All members who have fulfilled these two conditions shall have equal rights and equal responsiblities in the Association, and regularly receive the Association journal. All State Medical Societies, with their constituent local societies, shall be recognized by the American Medical Association if they accept its Code of Ethics. Members of Canadian and Mexican medical societies shall be admitted to membership upon the same terms as those in the United States. The regular graduates of such schools and colleges of dentisty as require of their students a standard of general education and a term of professional study equal to the best class of medical colleges in this country, and embrace in their curriculum all the fundamental branches of medicine differing chiefly by substituting practical and clinical instruction in general medicine and surgery, are recognized as members of the regular profession, and eligible to membership upon the same terms as other members. No person shall be permitted to take part in any annual meeting until he or she has completed the conditions of membership at that meeting, and can exhibit certificates to this effect from the Committee of Arrangements. But suitable persons may be introduced as guests, either at the general session or the Section sessions, and be invited to engage in the scientific and social exercises of the meeting without taking part in the transaction of business.

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[1] The words "State society," as used in this report, are intended to refer to and include the District of Columbia and every general medical society in any Territory that has the same scope and purpose as our State societies.

Meetings.—The regular meetings shall be held annually at such time and place as may be advised by the Business Committee and ordered by the Association. The details of these meetings are stated in the By-Laws.

Officers.—The officers of this Association shall be a President, four Vice-Presidents, one Secretary, one Assistant Secretary, a Treasurer, and a Librarian. These officers shall hold office during one year or until their successors are elected, and shall enter upon their duties immediately after election.

The President shall preside at the meetings, preserve order and decorum in debate, giving a casting vote when necessary, and perform all the other duties that custom and parliamentary usage may require. At the opening session he shall deliver an address to the general meeting, not to exceed thirty minutes in length.

The Vice-Presidents may be called upon to assist the President in the performance of his duties, and during his absence, or at the request of the President, one of them shall officiate in his place.

The Secretary shall record the minutes of the general sessions and authenticate the proceedings; give due notice of the time and place of the next annual meeting; notify all members of committees of their appointment and the duties assigned to them; hold correspondence with other organized medical societies, both domestic and foreign, and carefully preserve the archives and unpublished transactions of the Association. For his personal expenses in attending the annual meetings, the Secretary shall draw upon the Treasurer of the Association.

The Assistant Secretary shall aid in recording and authenticating the proceedings of the Association; serve as a member of the Committee of Arrangements, and perform all the duties of the Secretary, temporarily, whenever that office shall be vacant by death, resignation, or removal.

The Treasurer shall have the charge and management of the funds of the Association. He shall give the Board of Trustees bonds for the safe keeping and proper use and disposal of his trust. Through the same Board he shall present his accounts, duly authenticated, at each regular meeting. He shall each month furnish the President of the Board of Trustees with a statement of accounts for the guidance of the Board in its expenditures. For his personal expenses in attending the annual meetings, he shall draw upon the treasury through the President of the Board of Trustees.

The Librarian shall receive and preserve all property in books, pamphlets, journals, and manuscripts, presented to or acquired by the Association, record their titles in a book prepared for this purpose, and acknowledge the receipt of the same. He shall deposit these documents in such place and manner as the Association may direct, after advising with the Board of Trustees.

Standing Committees.—The Committee of Arrangements shall be composed of at least seven members, of whom the Assistant Secretary shall be one, all residing in the place at which the Association is to hold its next annual meeting. It shall provide suitable accommodations for the meeting; shall verify and report upon the credentials of membership; shall issue credentials of membership to such as fulfil the conditions; shall publish the rules governing the reading and discussion of papers and the order to be observed in the business of the general and sectional meetings; shall receive and announce all papers communicated, and, with the several Section Secretaries determine the order in which the papers shall be read and discussed; shall prepare a list of members present on a separate roll for convenience in calling the ayes and noes, when these are demanded; it shall have each member register his name, address, and place of stopping during the annual meeting, and the name of the Section that he will attend and in which he will vote for Section officers. The expenses of hall for general meeting, of rooms for the Sections, and cards of membership, shall be met by the Association. Should the committee incur other expenses, it must meet them from its own resources. The committee shall be nominated by the Business Committee, and elected by the Association.

The Board of Trustees shall consist of nine members, three of whom shall be elected annually, on nomination of the Business Committee, and serve for three years. This Board shall manage all matters relating to finance and publication. Thus it must provide for and superintend the publication and distribution of all such proceedings of the Association as may be ordered to be published, in such manner as the Association may direct. In doing this it shall have authority to appoint an editor and such assistants as may be necessary, and to determine their salaries. It shall procure and control such materials as may be necessary for the performing of the duties assigned it. To the Board or its representatives must be delivered, during the annual meeting, or as soon thereafter as is possible, by the Secretary of the Association and by the Section Secretaries or Executive Committees, all records of meetings, papers, or discussions, and such other documents as were ordered published by the Association. All money received by the Board of Trustees or its agents, resulting from the discharge of the duties assigned them, must be paid to the Treasurer of the Association, and all orders for disbursements of money, in any way connected with the work of publication, must be endorsed by the President of the Board of Trustees. It shall further be the duty of the Board of Trustees to hold the official bond of the Treasurer for the faithful execution of his office; to annually audit and authenticate his accounts, and present a statement of the same to the Association. This report must specify the character and cost of all publications of the Association during the year; the number of copies still on hand, and the amount of all other property belonging to the Association, under its control, with such suggestions as it may deem necessary. It shall yearly publish a list of members, their addresses in full, year of admission, the Constitution and By-Laws and Code of Ethics, and such other information as may be deemed useful, for yearly distribution to the members at each meeting. At the opening of each volume it shall publish a disclaimer by the Association for any responsibility for opinions expressed in the volume. To this Board must be referred all propositions for the appropriation of money, to be considered and reported upon before the final action on the same by the Association.

The General Business Committee shall be composed of the several Section Executive Committees, selected as hereafter described. It shall hold daily meetings during the sessions of the Association, and such other meetings as may be deemed necessary for the performance of its duties. All matters of business not provided for by the Committee of Arrangements, the Board of Trustees, the Judicial Council, and Special Committees, shall be referred to it without debate, for consideration and report to the Association. In general, this Business Committee shall give especial attention to the interests of the Association as a whole, and through these interests shall seek the development of the Sections; it shall consider all matters of business referred to it by the Association, and report upon them at the earliest possible moment, when the Association may accept or reject said report, as it may deem best. It shall be the duty of this Committee to seek the removal of such obstacles as interfere with the cordial coöperation in the Association of all competent, honest practitioners of rational medicine throughout this continent, and to promote every means by which coöperation shall be effected and maintained. Further, the General Business Committee shall make and present the nominations for officers of the Association and its Standing Committees, and recommend the time and place of the ensuing meeting. It shall appoint its own officers, and adopt rules for the orderly performance of its duties. Finally, it is expected that it will perform all its duties in the interests of the advancement of scientific medicine.

The Judicial Council shall consist of twenty-one members, whose duty it shall be to take cognizance of and decide all questions of an ethical or judicial character which may arise in connection with the Association. It is distinctly understood that neither this Council nor the Association shall take cognizance of differences arising between the members of any State or local society. Such differences must be settled by such societies themselves, and the Association will accept such decision as final. Of the twenty-one members first appointed, the first seven named upon the list shall hold office one year, and the second seven two years. With these exceptions, the term of office of the members of the Judicial Council shall be three years, seven being nominated by the Business Committee yearly, and elected by the Association. The Council shall organize by choosing a President and Secretary, and shall keep a permanent record of its proceedings. The decisions of said Council shall be final upon all ethical questions referred to it by the Association, and must be accepted without debate. Such decisions shall be reported to the Association as soon as practicable. All questions of a personal character, including complaints and protests, and all questions on the ethical standing of medical societies, shall be referred at once, when presented to the Association, to the Judicial Council, and without debate.

Income and Expenses.—The income of the Association shall be derived from subscriptions to its journal and advertisements therein, from specific publications and voluntary contributions for specific objects. Its funds may be appropriated for the expenses of halls, for general sessions and Section meetings, and for cards of membership, and such other expenses of the annual meeting as are essential for the conduct of the routine work; for meeting the necessary personal expenses of the Secretary and Treasurer while attending the annual meetings and in conducting the necessary correspondence; for publications; for enabling standing committees tofulfill their respective duties and conduct their correspondence; for the encouragement of scientific investigation by prizes, and for defraying the expenses of scientific investigation under the instruction of the Association, where such investigation has been accompanied with an order upon the Treasurer to supply the funds necessary for carrying it into effect.

Amendment.—No amendment or alteration shall be made in any of these rules except at an annual meeting next subsequent to that at which such amendment or alteration may have been proposed, and then only by the voice of three-fourths of all the members present. Provided, however, that when an amendment is properly under consideration, and an amendment thereto is offered germane to the subject, it shall be in order, and, if adopted, shall have the same standing and force as if proposed at the preceding meeting of the Association.

By-Laws.

Order of Business.—The order of business at the annual meetings of the American Medical Association shall be subject to the vote of three-fourths of all the members in attendance. Until thus altered, except when suspended, it shall be as follows:

1. Calling the meeting to order by the President.
2. The report of the Committee of Arrangements on the credentials of members, after the latter have registered their names and addresses; and on such other matters as it desires to present to the Association.
3. The reception of guests of the Association.
4. The annual address of the President.
5. The reception of reports from all special committees.
6. The reading and consideration of reports of standing committees, the Board of Trustees, Business Committee and Judicial Council.
7. New business and instructions to standing committees.
8. The report of the Business Committee and the election of officers of the Association; the selection of next place of meeting.
9. Reports from the Executive Committees of the Sections.
10. Reading of the minutes by the Secretary.
11. Unfinished and miscellaneous business.
12. Adjournment.

Meetings.—The annual meetings of the American Medical Association shall be held in May if the place be in the South, and in June if the place be in the North. The day of opening of the general sessions shall be on the first Tuesday after the first Monday of the month selected. The hour on the opening day shall be 10 A. M., and on the following days 4:30 P. M.

Sections.—The several Sections shall hold their first meeting at 1:30 P. M. on the first day, and at 9 A. M. and 1:30 P. M. thereafter daily. The several Sections are as follows:

1. Practical Medicine and Physiology.
2. Obstetrics and Diseases of Women.
3. Surgery and Anatomy.
4. State Medicine.
5. Opthalmology.
6. Diseases of Children.
7. Dental and Oral Surgery.
8. Medical Jurisprudence and Neurology.
9. Dermatology and Syphilis.
10. Laryngology and Otology.
11. Materia Medica and Pharmacy.

Officers of Sections.—The officers of each Section shall consist of a Chairman, Secretary and Executive Committee. The Chairman and Secretary shall be elected annually, immediately after the Section is called to order on the afternoon of the second day. During the session of the first day, the Chairman shall appoint a Nominating Committee, consisting, if practicable, of ex-chairmen of the Section, to report at the opening of the afternoon session of the second day. Election shall be by ballot.

The Executive Committee of each Section shall, when first appointed, consist of three members from among those who have been in attendance at the sessions of the Section for at least two years, to serve for one, two and three years respectively; and thereafter the retiring Chairman of the Section shall take the place upon the committee of the retiring member. It shall be the duty of the Executive Committee, in conjunction with the Chairman and Secretary, to give special attention to the interests of their own Section. Thus they shall secure the annual republication from *The Journal* of the work of the Section, its papers and discussions, lists of officers, lists of all members of the Section, with their addresses, and rules adopted by the Section for the conduct of its work, securing from the Section the funds needful for the performance of this purpose. They shall carefully edit all publications of the Section, and secure a creditable mechanical execution of the same. They shall also take such measures as in their judgment will secure the cordial coöperation of all reputable workers in their special fields in North America. If desired by the Section, they will make arrangements for an inexpensive annual dinner for their individual Section. Further, these several Executive Committees of the Sections shall meet together and form a General Business Committee of the Association, with powers and duties described under the head of the General Business Committee.

The Chairman of each Section, in addition to his duties as a presiding officer and a member of the Executive Committee, shall read a short address at the opening of the session on the first day. In conjunction with the Secretary, he shall secure from members papers to be read, and arrange for the discussion of the same. This order of Section work he shall communicate to the Chairman of the Committee of Arrangements at least one month before the annual meeting.

No paper read before the Sections shall occupy more than twenty minutes. If it be longer, the writer should make such an abstract as will bring it within the limit, and present it for discussion. No person shall discuss any paper more than once, or speak longer than fifteen minutes without unanimous consent. No paper shall be read before any Section that is not in such condition as to pass at once from the reader's hands to the Executive Committee of the Section. Within thirty days, said committee must forward the entire work of the Section to the Board of Trustees, with such recommendations as it deems proper. But no paper shall thus be sent by an Executive Committee that does not fall under one of the following heads: (1) Such as may contain and establish new facts, new modes of practice or new principles of real value. (2) Such as may contain the results of well devised original experimental research. (3) Such as present so complete a review of the facts on any particular subject as to enable the writer to deduce therefrom legitimate conclusions of importance. Other papers containing material of more or less value shall be returned to their authors, to be published as they may desire, with the statement that they were read before said Section of the American Medical Association. In general, it is expected that each Executive Committee will make every effort to secure for its special Section, papers and discussions which will fairly represent the active workers in their department of medicine, and otherwise promote cordial good will among the several workers therein.

Publication of Papers and Reports.—All papers and reports must be so prepared as to require no material alteration or addition at the hands of authors. All Section work must be in the hands of the Trustees within thirty days after the annual meeting. Proofs will be sent authors, but they should be returned at the earliest possible moment, and unless returned within two weeks, will be omitted from *The Journal.* Every paper requiring it, shall be illustrated at the expense of the Association, should it accept the same for publication. Every paper accepted is understood to be contributed exclusively to the Association Journal, though brief extracts of the same may be published elsewhere. In case of an article that is of especial value, the result of expensive research or experimentation, the Trustees, at their discretion, may compensate the writer in accord with the usual price of such work. The Board of Trustees has the power to reject any paper referred to it, unless especially instructed to the contrary by the Association.

Dues.—Each member of the Association shall pay his annual subscription to *The Journal* of five dollars before receiving from the Committee of Arrangements his membership ticket to the annual meeting. The evidence of this shall be the Treasurer's receipt for the five dollars. Any member failing for one year to pay this subscription shall be dropped from the rolls.

Delegates.—The President of the American Medical Association is authorized to appoint members, desiring such appointment, as delegates to the several medical and scientific bodies that are in sympathy with the Association.

Duties of Members.—No one shall be permitted to address the Association unless he first shall have given his name and address, which shall be distinctly announced from the chair. If desirable, the member may be required to go forward and speak from the platform. Failure to do special committee work shall cause the offender to forfeit a continuance of the same appointment, or a place upon any other, unless satisfactory excuse is offered. It is expected that every member will, in all ways available to him, promote the interests of the medical profession as represented in the Association. He is expected to conform to all its regulations in spirit and letter until they may be altered by the action of the body which formulated them.

Conditions Excluding from Membership.—All societies that reject the Code of Ethics of the American Medical Association, or intentionally violate or disregard any article of the same, are thereby of their own choice debarred from membership.

The Previous Question.—When the previous question is demanded, it shall take at least twenty members to second it. When the main question is put under force of the previous question and negatived, the question shall remain under consideration, the same as if the previous question had not been enforced.

New Business.—No new business, or resolutions by members, shall be introduced at the general session of the Association, except on the first and fourth days of the meetings.

Eligibility to Office.—In the election of officers and the appointing of committees by the Association and its President, they shall be confined to members present at the meeting, except in the Committee of Arrangements.

Medical and Surgical Exhibit.—There shall be no medical and surgical exhibit, under the authority or recognition of the American Medical Association, other than that made before the several Sections under the supervision of the Business Committee. All that is new and of value to the scientific or practical physician can thus find an appreciative audience. Experience has shown that all other exhibits detract from the work in Sections, and so lessen the attractiveness of the annual meetings to those whose presence is desirable.

Signed: H. D. HOLTON, *Chairman.*
LEARTUS CONNOR.
DANIEL E. NELSON.
BENJAMIN LEE.

Minority Report.

The minority of the Committee on Revision of the Constitution and By-Laws, respectfully reports:

That after a study of the printed new Constitution and a comparison of it with the present one, more careful, thorough, and prolonged than was possible at the meeting of the Committee in Buffalo, he has felt constrained to disapprove some of the radical changes adopted by the Committee, and to withdraw his name from the report. He believes that the retention of the government of the Association in the hands of delegates chosen annually as their representatives by State and local societies, would continue to be a safeguard against possible evils of great magnitude, and would secure the stability and promote the welfare of the Association.

He also believes that taking away from the representatives of the various State and County Societies, assembled at the annual meetings, the right to choose the Nominating Committee and bestowing it upon the Business Committee would be unfair, unjust, and deservedly unsatisfactory to the great majority of the Association. Signed, HENRY D. DIDAMA.

CODE OF ETHICS.

Your committee appointed to consider the advisability of amending your Code of Ethics, have had the subject under consideration, and at one time outlined the changes which they believed desirable. The matter was committed to one of its members to write out. However, pressure of other affairs, beyond his control, prevented his doing so. In addition, the following new questions have pressed for consideration. What should be the relations of the profession to railroad and other corporations, to accident insurance companies and other societies, to free dispensaries, to hospitals, and to other institutions? The data for answering these questions were not at hand, and would require much time to collect and carefully study. We therefore desire at this time to report progress, and ask for further time to perfect our report. We would, however, suggest the following as tending to promote the spirit of equity between physicians, and so increase professional prosperity:

First—We would omit all sections of the Code that describe the obligations of patients to their physicians, and of the public to physicians. The reason for this suggestion is that the Code is not designed either for patients or the public, and so the sections are superfluous. This omits ten sections under Article II, on pages 5, 6, 7 and 8, and Article II, on page 20.

Second—We suggest the placing in the same list with the copyrighting of medical books and other similar work, the patenting of all mechanical appliances used in medicine or surgery. The Code says nothing respecting the copyrighting of medical publications, and we find no good reason why it should say anything respecting the patenting of mechanical devises.

Third—We recommend the more accurate definition of the term "consultation," as we find good reason to believe that serious estrangement has arisen between physicians because of the different ideas they attached to this term. The Code of Ethics, page 14, second line from top, says that in a "consultation" the responsibility must be equally divided between the medical attendants—they must equally share the credit as well as the blame of failure. With this statement before us, it is clear that there can be no consultation when one physician meets another for the purpose of obtaining from him an account of the case, or pertinent facts of family history, or a record of the past management of the case, in order that he may more intelligently assume the entire responsibility of its future conduct. Thus the existing Code of Ethics of the American Medical Association defines a consultation substautially as a meeting of doctors to discuss a case to the end that they may equally share in its further management. By the same authority a consultation is not a meeting of physicians with a case, in which one gets all the facts possible from the other or others, as a preliminary to his assuming entire responsibility in its future conduct.

From these data it is clear that usually the specialist does not consult with the general practitioner. He simply obtains all the facts the general practitioner possesses, preparatory to assuming full control of the case. There are many other occasions for the meeting of medical men, in connection with cases of sickness, that are in no sense consultations according to the existing Code.

Hence we think that in the interest of scientific accuracy, there should be a discrimination made in the study of consultations, as present conditions differ widely from those of forty or more years ago.

Having premised this much, your committee recommends the alteration of Art. IV, Sec. 1, page 11, Code of Ethics, to read as follows: "A thorough medical education furnishes the only presumptive evidence of professional abilities and requirements, and ought to be the only acknowledged right of an individual to the exercise and honors of his profession. Nevertheless, as the good of the patient is the sole object in view, and this is often dependent upon personal confidence, no intelligent practitioner, who has a license to practise, from some medical board of known and acknowledged legal authority to issue such license, and who is in good moral and professional standing in the place in which he resides, should be refused consultation when it is requested by the patient."

Fourth.—It is suggested that it would be wise to re-write the Code in phraseology so plain as to make it a practical, common-sense document for daily guidance in the performance of our various duties and an aid in meeting responsibilities incident to our professional life.

Finally, your committee found that in but few medical colleges has this document been taught, and never as a portion of the required curriculum.

It is believed that professional success of the best sort depends as well upon a practical knowledge of medical manners and medical ethics as upon anatomy, physiology, pathology, therapeutics, or surgery. To be master of the rules of conduct by which our neighboring doctors can be made our friends and kept such, so that the people may see that the medical men who serve them form a band of brothers devoted to the service of suffering humanity, is to possess a most desirable professional resource. The committee finds the Code of Ethics contains the essentials for the successful conduct of a medical career, as these have been learned by the actual experience of the best members of the medical profession, from the earliest dawn of history to the day on which it was written. It sincerely trusts that the present discussion will lead to a more intelligent appreciation of its truths by all physicians, and especially that hereafter it will be made a text-book in every medical college, and an accurate knowledge of its contents be made a condition of receiving the degree of Doctor of Medicine.

The committee deprecates all efforts to abolish, belittle, distort, ridicule, or otherwise lessen, its hold upon the profession. It is a heritage representing at once the best characteristics of our profession during all its history, and a scientific document that points out the line of greatest prosperity in the future. It would seem better far, that, in the spirit of scientific students, we patiently inquire whether in any respect the changes incident to the last half century warrant any modifications of statement of any portion of this document in the interest of good to all and ill to none, for the increased prosperity of medical art and science and a more united professional power over those whom we serve.

Signed: HENRY D. HOLTON, *Chairman.*
LEARTUS CONNOR.
DANIEL T. NELSON.
BENJ. LEE.

Minority Report.

The minority of the Committee on Revision has the honor to report against any kind of revision of the Ethical Code:

1. Because the language of the Code is clear, concise, and accurate, and conveys to the mind the soundest ethical principles derived from the moral maxims of all civilized nations, compiled and admirably arranged by practical men of acknowledged ability and wisdom.
2. Because the Code is explicit, liberal, broad, humane, and founded on truth, justice, and reason, and is free from magisterial assumption or oppressive exaction.
3. Because the Code contains full particulars, without superfluous details, for the guidance of all physicians, for the instruction of beginners, and for the information of the people.

Signed, HENRY D. DIDAMA.

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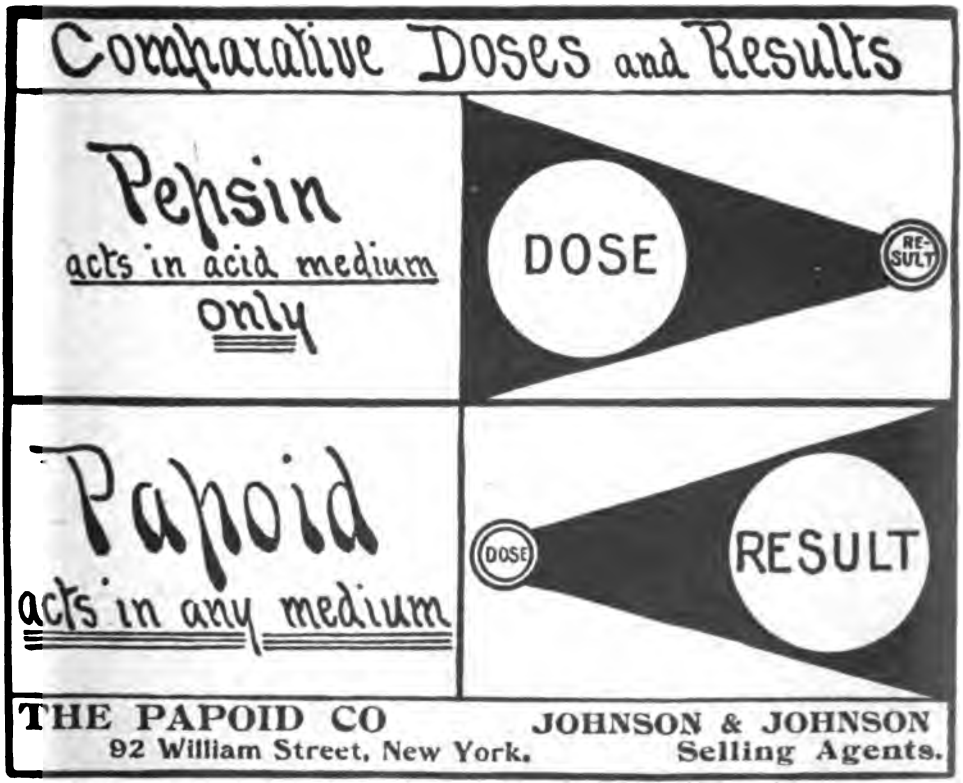

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Formula—Each Dose Contains: *Pure Norwegian Cod Liver Oil, 80 m. (drops), Distilled Water, 35 m. (drops), Soluble Pancreatin, 5 grains, Soda, 1/6 grain, Salicylic Acid, 1/4 grain.*

DOSE.—Two teaspoonfuls alone or mixed with twice quantity of water, to be taken after each meal.

HYDROLEINE is a pancreatized Cod Liver Oil preparation of pure Norwegian Cod Liver Oil (from Lofoten), that is prepared as the direct result of a long series of physiological experiments, conducted by H. C. Bartlett, Ph. D., F. C. S., and G. Overend Drewry, M. D., M. C. R. S., and encouraged with many practical suggestions by Bence Jones and Baron Liebig.

HYDROLEINE is based on sound scientific principles; it is easily digested and assimilated, without producing eructations. Appetite is increased, and that, so far from possessing the unpleasant taste of Cod Liver Oil and its emulsions, HYDROLEINE is palatable as milk, and pleasant. The formula is well known and the preparation has received the endorsement of physicians throughout the United States. It is sought to introduce HYDROLEINE exclusively on its merits, and for that reason the profession is appealed to only through the columns of medical journals.

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One ounce of this new Remedy is, for its Bactericide Power, equivalent to two ounces of Charles Marchand's Peroxide of Hydrogen (medicinal), which obtained the Highest Award at the World's Fair of Chicago, 1893, for

Stability, Strength, Purity and Excellency.

CURES DISEASES CAUSED BY GERMS:

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Hydrozone is put up only in small, medium and large size bottles, bearing a red label, white letters, gold and blue border, with signature.

Charles Marchand's Peroxide of Hydrogen (medicinal) is put up only in 4-oz., 8-oz., and 16-oz. bottles, bearing a blue label, white letters, red and gold border, with signature.

Glycozone is sold only in 4-oz., 8-oz., and 16-oz. bottles, bearing a yellow label, white and black letters, red and blue border, with signature.

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The coating of the following granules will dissolve in 1¼ minutes

Acid Arsenious .... 1/20, 1/30 and 1/60 gr.
Med. Prop.—Antiperiodic, Alterative.
Dose, 1 to 2.

Aconitia .... 1/60 gr.
Med. Prop.—Nerve Sedative.
Dose, 1 to 2.

Aloin et Strychnine ....
Med. Prop.—Tonic, Laxative.
Dose, 1 to 2.

Aloin et Strychnine et Belladonna ....
Med. Prop.—Tonic, Laxative.
Dose, 1 to 2.
Aloin, 1/5 gr.
Strychnine, 1/60 gr.
Ext. Belladon. ⅛ gr.

Atropine .... 1/100 gr.
Med. Prop.—Anodyne.
Dose, 1 to 2.

Atropinæ Sulph. .... 1/60 gr.
Med. Prop.—Anodyne.
Dose, 1 to 2.

Caulophyllin .... 1/10 gr.
Med. Prop.—Emmenagogue.
Dose, 1 to 4.

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Med. Prop.—Anodyne, replacing morphia, without the usual disagreeable after effects produced by the latter.

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Dose, 1 to 2.

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Med. Prop.—Diuretic, Hydragogue Cathartic.
Dose, 1 to 2.

Ext. Belladonna (English) .... ¼ gr.
Med. Prop.—Anodyne.
Dose, 1 to 2.

Ext. Ignatia Amara .... ¼ gr.
Med. Prop.—Nerve Sedative.
Dose, 1 to 2.

Ext. Cannabis Indica .... ¼ gr.
Med. Prop.—Anodyne.
Dose, 1 to 4.

Ext. Hyoscyam. (English) .... ¼ gr.
Med. Prop.—Nerve Stimulant.
Dose, 1 to 3.

Ext. Nux Vomicæ .... ¼ and ½ gr.
Med. Prop.—Nerve Stimulant.
Dose, 1 to 3.

Hyoscyamia (Crystals Pure Alkaloid) .... 1/100 gr.
Med. Prop.—Anodyne, Soporific.

Leptandrin .... ¼ gr.
Med. Prop.—Cathartic.
Dose, 1 to 4

Mercury Prot. Iodid. .... ¼ gr.
Med. Prop.—Alterative.
Dose, 1 to 4

Mercury Prot. Iodid. .... ⅓ gr.
Med. Prop.—Alterative.
Dose, 1 to 2.

Mercury Prot. Iodid. .... ⅛ gr.
Med. Prop.—Alterative.
Dose, 2 to 4.

Mercury Iodide Red .... 1/16 gr.
Med. Prop.—Alterative.
Dose, 1 to 3.

Morphine Sulph. .... 1/20, 1/16, ⅛, ⅙, ¼ and ½ gr.
Med. Prop.—Anodyne.

Podophyllin .... 1/10, ¼, ½ and 1 gr.
Med. Prop.—Cathartic.
Dose, 1 to 4.

Podophyllin Comp. ....
Med. Prop.—Cathartic and Tonic.
Dose, 1 to 2.
Podophyllin, ½ gr.
Ext. Hyoscyamia, ⅛ gr.
Ext. Nux Vomicæ, 1/10 gr.

Strych. .... 1/100, 1/20, 1/30, 1/32, 1/40 and 1/60 gr.
Med. Prop.—Nerve Stimulant and Tonic.
Dose, 1 to 3.

Strychninæ Sulph. .... 1/32 gr.
Med. Prop.—Tonic.
Dose, 1 to 2.

Veratrinæ Sulph. .... 1/12 gr.
Med. Prop.—Powerful Topical Excitant.
Dose, 1.

Zinc. Phosphide .... ⅛ and ¼ gr.
Med. Prop.—Tonic.
Dose, 1 to 3.

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A Powder; prescribed in the same manner, doses and combinations as Pepsin, with superior advantages.

A SPECIFIC FOR VOMITING IN PREGNANCY,

IN DOSES OF 10 TO 20 GRAINS.

PUBLISHERS' DEPARTMENT.

Dr. R. Cantalupi, writing from Naples, Italy, under date of July 24th, 1893, says: Bromidia has produced successful results in all the most varied forms of Insomnia. Among others who have been benefited by its use is Prof. Cesare Olivieri, well known as a most distinguished surgeon in this city, and who, after undergoing tracheotomy for neoplasm in the larynx, suffered terribly from Insomnia, which the usual hypnotics all failed to relieve. Hearing of this, from a mutual friend, I advised the use of Bromidia, which promptly produced the desired result.

Treatment of Asthma.—

℞.	Chloroform	1 drachm.	
	Co. Tinct. Cardom.	1 ounce.	
	Syrup Acacia	1 drachm.	
	Ether	1½ ounce.	M.

Sig.: Shake well. Teaspoonful every hour until relieved.

At the same time the administration of the Elixir Six Iodides is to be prescribed, for it is our experience that the Iodides are invaluable in Asthma. It should be administered for years, suspending its use every third or fourth month.

A Pronounced Opinion From the Veteran Editor of the "Memphis Medical Monthly." To the Antikamnia Chemical Co., October 22, 1894. *Gentlemen:* Your kind favor of 20th inst. received this evening, after my return from Ship Island, Miss. The "Antikamnia and Codeine Tablets," which reached me also, were exactly what I wanted. Having been exposed to the gulf breezes all day, I returned suffering intensely with gastralgia and pleurodynia. One of the tablets gave me relief, and I have since had my supper and feel quite comfortable. In the fact that your preparation, Antikamnia, has no depressing effect upon the cardiac force, you have much for congratulation, and the field for its usefulness may be viewed like the horizon—the nearer you approach it the wider its recognized extent. Yours cordially, F. L. SIM, M.D.

The following item appeared in the last number of the *Alienist and Neurologist*, Dr. C. H. HUGHES, editor. *Antikamnia.*—The adoption of the monogram on the new tablets and the recall of all the old stock from the market, will prove of benefit to this firm and the many physicians who may hereafter desire to afford relief by its use. It will henceforth be sold only in tablet form. This item appeared in all friendliness to Antikamnia, than whom no better friend exists than Dr. Hughes, and the first paragraph is a succinct statement of an undoubted fact. It is to the last sentence we call your attention particularly, and which, if permitted to go unnoticed, will mislead and injure the demand for "Antikamnia Powdered," its most popular form. The changes in style of packages and form of tablets in no sense changes Antikamnia, nor withdraws "Antikamnia Powdered" from the market, which remains now as always, and in stronger demand than ever.

Clinical Experiences with Solutions of Pyrozone.—Dr. FRANK L. SHATTUCK, of the Detroit College of Medicine, says: "Having used all your preparations of pyrozone quite extensively, I can vouch for its merit, consequently it will not be necessary to reiterate what has already been said. I always rely on surgical treatment for a curative process in pyorrhœa alveolaris; afterward prescribe to the patient pyrozone 3 per cent. as a palliative. As pyrozone, after its decomposition, leaves no material in the system which is foreign, it is, therefore, the most efficient and harmless disinfectant or prophylactic that can be used, in all forms, in all forms of purulent inflammation. In the 25 per cent. solution (aside from its use in pyorrhœa) I find it the 'acme' of protection in restoring discolored teeth. To be able to enliven its energy by heat is a truly remarkable power, as upon heat we depend very greatly. I might add that in all the several applications of pyrozone heat will only render its power more effective."

Treatment of Gonorrhea.—I. HUMPHREY, M.D., Fairbury, Neb., says: The cure of gonorrhea, in some cases, is no trifling matter, as I long ago learned, not from books, but by experience. Such remedies as the doctor describes will often produce just such results, or did for me in my early practice. Any preparation of mercury, sulphate of zinc, nitrate of silver, acetate of lead, or, in fact, any and all astringents too strong, given in the early stage of gonorrhea, will be very likely to result in stricture or orchitis. Many cases thus treated come to me from other M. D.s. It is far better to do nothing than to use such remedies, especially in the early stage. Never use any medicine the first two to four days after the discharge appears. Use only warm water frequently injected with a P. P. vulcanized syringe (use no glass syringe). Use the injection immediately after urinating, so as to avoid carrying the virus further up the canal. Give at the commencement a laxative of any bland cathartic, if necessary, to keep the bowels loose. After three or four days' use of warm water, use instead:

℞.	White Pinus Canadensis (Kennedy's)	1 ounce.
	Morphia sulph.	15 grains.
	Aqua fow.	5 ounces.

M. Sig.: After passing urine to wash out the canal, inject a full P. P. syringe of the medicine, holding it in the penis three or four minutes. Use three times a day.

If more than one bottle is required, fill the bottle each time after the first is gone, just the same, only use two ounces of the Pinus Canadensis; order plenty of nurishment, no intoxicating drinks, avoiding all excesses, and you will have no case of orchitis, or stricture, and last but not least, make no failures, nor will even need to blister the penis.

The Marvelous Kola Nut.—WASHINGTON, November 19. The State Department has been calling upon the United States consuls in Africa for specific information respecting the marvelous Kola nut, which, by its pecular action upon the muscular system, enables the African negroes to make long journeys, bearing enormous loads, under tropical suns and across difficult country without food. Cases authentically reported prove that an old negro may carry a 176-pound bag of coffee four leagues by chewing a single nut slowly. Robert P. Portley, United States consul at Sierra Leone, Africa, has sent in the first report on this subject, treating of the means of growing and preparing the nuts. He says the natives eat the nuts in early morning as a stay against the want of ordinary food, while traveling, and in the evening to induce sleep. Altogether they consider that a general benefit to the human system is derived from the consumption of the Kola, say a single nut morning and evening.—*Detroit Free Press.*

[We are just in receipt of an exhaustive Monograph of Kola, issued by the Scientific Department of Frederick Stearns & Co., Detroit, Mich., which gives full information regarding the wonderful tonic stimulant properties of this drug, and many interesting facts relating to its growth and the important part it plays in the social intercourse between the natives of Africa, where it is indigenous. Messrs. F. Stearns & Co. were the introducers of Kola nuts to the medical and pharmaceutical professions of the United States, being the first to offer the drug for sale in the begining of the year 1881. They are headquarters for Kola nuts in this country, importing them in the fresh state in immense quantities direct from Africa. Any physician who is desirous of obtaining a sample of the fresh nuts for planting, or a copy of the Monograph on Kola should address their Scientific Department.]

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"COMPOUND TALCUM"
"BABY POWDER,"

The "Hygienic Dermal Powder,"
FOR INFANTS AND ADULTS.

Originally investigated and its therapeutic properties discovered in the year 1868, by Dr. Fehr, and introduced to the medical and the pharmaceutical professions in the year 1873.

COMPOSITION: Silicate of Magnesia, with Carbolic and Salicylic Acids.

PROPERTIES: Antiseptic, Antizymotic, Disinfectant.

Useful as a GENERAL SPRINKLING POWDER, with positive Hygienic, Prophylactic, and Therapeutic properties.

GOOD IN ALL AFFECTIONS OF THE SKIN.

SOLD BY THE DRUG TRADE GENERALLY.

Per Box, plain	25 cents	Per Box, perfumed	50 cents
Per Dozen, "	$1 75	Per Dozen, "	$3 50

THE MANUFACTURER:

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Ancient Pharmacist, *HOBOKEN, N. J.*

ELIXIR SIX IODIDES

The Elixir is prepared from the Chemically Pure Salts.

Results can be looked for from its administration that could not possibly be expected from the Commercial Salts.

FORMULA: Each fluid drachm contains Arsenici Iodidum, 1-125 gr., Ferri Iodidum, 1-12 gr., Hydrargyri Iodidum., 1-125 gr., Manganesii Iodidum, 1-10 gr., Potassii Iodidum, one gr., Sodii Iodidum, one gr., with Aromatics.

MEDICAL PROPERTIES:—The greatest VALUE of this COMBINATION is, it relieves those OBSCURE and CHRONIC OBSTRUCTIONS to GLAND ACTION—the KIDNEY, LIVER, PANCREAS, as well as the LYMPHATIC SYSTEM, which may exert so great an influence for evil on the economy. It enjoys the confidence of the medical profession, and its use is indicated in a wide range of diseases, particularly so in PERNICIOUS ANAEMIA, SKIN DISEASES, both SCALY and PAPULAR; has remarkable curative effects in SPECIFIC DISEASES and other manifestations of SYSTEMIC INFECTION, CHRONIC UTERINE and PELVIC DISEASES, and in complaints where an ALTERATIVE and TONIC is indicated. This COMBINATION proves that the UNITED ACTION OF REMEDIES is often requisite when either alone, is insufficient. Physicians, when prescribing, will please write: Elixir Six Iodides—Walker-Green's—One Bottle. The druggist will please write directions on his own label. ELIXIR SIX IODIDES is always sold in eight oz. oval bottles and NEVER IN BULK. Attention is also called to our **ELIXIR SIX BROMIDES, ELIXIR SIX HYPOPHOSPHITES** and **ELIXIR SIX APERIENS** which are unexcelled for clinical efficiency and palatability. Wholesale Price, per dozen, Iodides, $8; Hypophosphites, $6; Bromides, $6; Aperiens, $4. Send for Descriptive Circular. These Elixirs are kept in stock by wholesale druggists generally throughout the United States.

The Walker-Green Pharmaceutical Co.
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No. 180 W. Regent Street, Glasgow, Scotland, and Kansas City, U. S. A.
Samples of the four Elixirs will be sent to any physician, prepaid, on receipt of $1.00.

THE NEW ANTIPYRETICS.

As the season is approaching when it is reasonable to expect there may be more or less of *la Grippe* or Influenza, which prevailed in this country several years ago, *we desire to call the attention of the Profession to the compressed form for administering the following remedies*, insuring immediate therapeutic results, the COMPRESSED TABLET being much more readily soluble than the ordinary pill, with greater convenience and absolute exactness.

The large number of these COMPRESSED TABLETS which we have sold, has proven the efficiency of these remedies, as well as the great favor with which our process of compression has been received by the medical profession.

The absence of any excipient,—the Tablet consisting merely of the dry powder compressed—must commend itself to the physician; resulting in the rapid disintegration and assimilation by the system, which is not possible with the ordinary pill, prepared by means of gum or some other excipient, which hardens the mass and prevents rapid solubility.

The following comprise the remedies of this character which we are prepared to supply:

ANTIPYRINE, 1, 2, 3, 5 and 10 Grains.

ANTIPYRINE and QUININE.

(Antipyrine 2 grains, Quinia Sulph. 2 grains.)

ANTIPYRINE and SALICYLATE of SODA.

(Antipyrine 2 grains, Salicylate of Soda 2 grains.)

ACETANILID, 1, 2, 2 1-2, 3, 4, 5, and 10 Grains.

ACETANILID COMPOUND (Dr. Aulde's), 1-2 Grain.

(Acetanilide 7-20 grain, Caffeine 1-20 grain, Soda Bicarb. C. P., 1-10 grain.)

ALSO, 2 AND 5 GRAIN TABLETS OF THE SAME FORMULA.

ANALGESINE.

Acetanilide 3 grs., Chloride of Ammon. 1 gr., Citrate of Caffeine ½ gr., Bicarb. Sodium ½ gr.

ACETANILID and SALOL, 2 1-2 Grains of Each.

ANTIFEBRIN, 2, 3 and 5 Grains.

ANTIFEBRIN and CHOCOLATE.

(Antifebrin 5 grs., Sweet Chocolate 10 grs.)

PHENACETINE, 1-2, 1, 2, 3, 5 and 10 Grains.

PHENACETINE and CAFFEINE.

(Phenacetine 3 grs., Citrate Caffeine 1½ grs.)

PHENACETINE and SALOL.

(Phenacetine 2½ grs., Salol 2½ grs.)

A paper, embodying a number of formulæ as prescribed with marked success in both hospital and private practice in different phases of *la Grippe*, giving in detail the chemistry of all the ANTIPYRETICS and other remedial agents now being largely prescribed by our most eminent practitioners, for the prevailing disease, will be sent on application.

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A natural proteid compound of Iron, thereby differing entirely from ARTIFICIAL mixtures of albumen or peptone with Iron. Hæmoferrum is true blood Iron, aseptically prepared from fresh bullock's blood, and contains ALL the Iron of the blood. It is very soluble, of sweet odor, of pleasant taste, neutral in reaction, and is NON-STYPTIC, NON-IRITATING, and NON-CONSTIPATING; in short, it is hæmoglobin, the concentrated active principle of the blood itself, in its best form, viz., oxyhæmoglobin.

Hæmoferrum seems to possess all the desirable medicinal and therapeutic properties of Iron, without any of its objectionable features; therefore, we believe it unequalled as an Iron preparation, and earnestly request the Medical Profession to give it a thorough trial. ☞ *Samples, literature, and further particulars free on application.*

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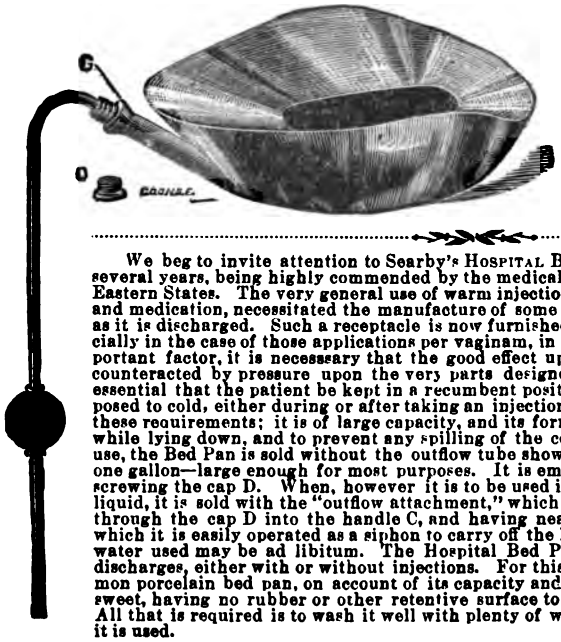
SEARBY'S HOSPITAL BED PAN



We beg to invite attention to Searby's Hospital Bed Pan, which has now been in use several years, being highly commended by the medical profession of this coast and of the Eastern States. The very general use of warm injections, both for purposes of cleanliness and medication, necessitated the manufacture of some suitable vessel to receive the fluid as it is discharged. Such a receptacle is now furnished in the Hospital Bed Pan. Especially in the case of those applications per vaginam, in which the warmth itself is an important factor, it is necessary that the good effect upon the circulation should not be counteracted by pressure upon the very parts designed to be relieved. It is therefore essential that the patient be kept in a recumbent position, and that she should not be exposed to cold, either during or after taking an injection. The Hospital Bed Pan meets all these requirements; it is of large capacity, and its form is adapted at once to fit the body while lying down, and to prevent any spilling of the contents on the bed. For ordinary use, the Bed Pan is sold without the outflow tube shown in the cut, as it holds, when full, one gallon—large enough for most purposes. It is emptied through the handle C by unscrewing the cap D. When, however it is to be used in cases requiring a large volume of liquid, it is sold with the "outflow attachment," which consists of a rubber tube running through the cap D into the handle C, and having near its lower end an elastic bulb by which it is easily operated as a siphon to carry off the liquid. In this case the quantity of water used may be ad libitum. The Hospital Bed Pan is also used for receiving rectal discharges, either with or without injections. For this purpose it is better than the common porcelain bed pan, on account of its capacity and form. It is easily kept clean and sweet, having no rubber or other retentive surface to hold offensive odors or secretions. All that is required is to wash it well with plenty of warm (not boiling) water every time it is used.

Physicians on the Pacific Coast can order the HOSPITAL BED PANS either of us direct, or of any pharmacist in their own vicinity.

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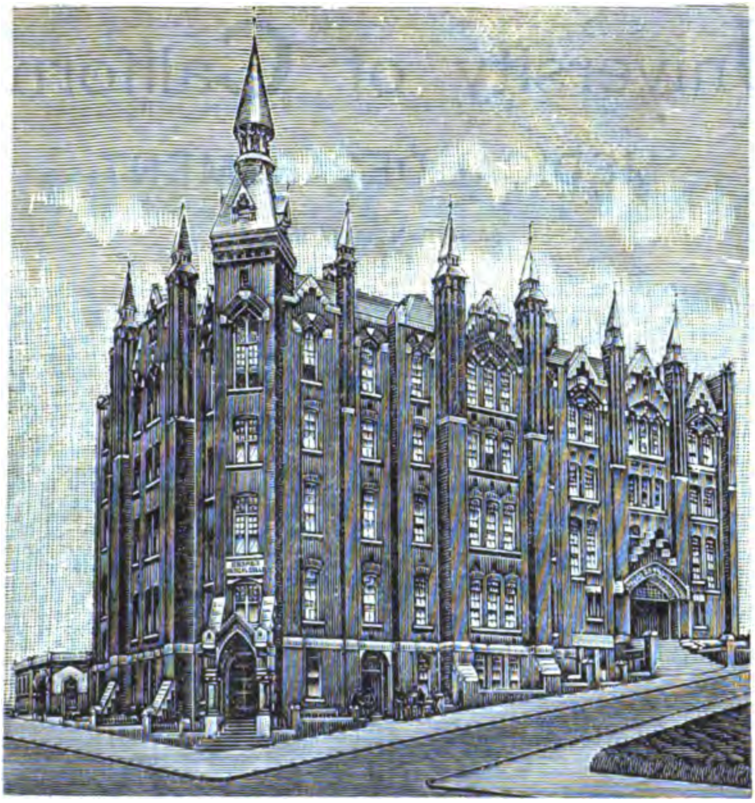

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SEASONABLE SUGGESTIONS.

With the opening of the winter season, and its attendant bronchial and pulmonary troubles, we are having from many sections reports of a recurrence of the *La Grippe* epidemic which for the past six or seven years has afflicted the country. This fact makes particularly pertinent a recalling of the salient points of DR. V. W. GAYLE's paper, first published in the *Medical World* in the midst of *La Grippe's* most malignant visit. It will be well to note closely his recommendations and experience in connection with the recurrence of the epidemic, which is now apparently upon us. He says: "This disease, by proper treatment of an attack, can be so modified as to be almost aborted. If not properly managed, influenza is particularly liable to grave complications; even in mild cases the tendency is towards prostration, and often the nervous shock is such as to materially debilitate the patient. Where there is much angina, with acute bronchial irritation, the following is indicated:

℞ Ammon. Chloridi .... ʒ ij
Potassii Chloras .... ʒ j
Tinct. Ferri Chloridi .... ʒ ij
Syr. Simplex .... ʒ ij
Aquæ .... *q. s. ft.* ℥ iv
M Sig.—Teaspoonful in sweetened water every four hours;
also apply to the throat with probang every three hours.

Quinine is the best germ destroyer we have for the microbe of influenza. During the recent epidemic I aborted quite a number of cases with antikamnia and quinine in combination; also with antikamnia and salol. The relief obtained by the administration of antikamnia alone, where the cephalalgia was severe, as in the majority of my cases, was wonderful. When the pain seemed almost intolerable, I have seen a ten-grain dose banish it.

Mustard pediluvia are of great advantage, and a plaster of mustard and lard, one part of the former to two of the latter, applied directly to the chest, answered admirably as a mild counter-irritant.

Expectorants are often needed and antikamnia should be administered with them, thus:

℞ Antikamnia (genuine) .... ʒ j
Syr. Senega .... ℥ j
Vini Ipecac .... ʒ iij
Syr. Tolutan .... *q. s. ft.* ℥ iv
Mix and let stand until effervescence ceases.
Sig.—Teaspoonful every two hours.

The mild chloride of mercury, in minimum doses often repeated, will be beneficial. Tle following prescription is a favorite of mine:

℞ Hydrarg. Chlo. Mit. .... gr. j
Sodii Bicarb. .... ℈ i
Lactopeptine (genuine) .... ʒ ss
M. ft. Chart No. X.
Sig.—One every hour until all are taken, followed by a full dose of hunyadi janos water."

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Gayle concludes his paper as follows: "What is mostly needed is an antithermic analgesic to relieve the pain and reduce the fever. These properties are found in antikamnia. This, with the germ-destroyer quinine, is all that I really needed in the treatment of this disease. I advocate the use of stimulants in nearly every case. They are frequently needed in the onset of the disease. Sprays of carbolic acid, turpentine or resorcin are frequently efficacious in the laryngeal troubles. The diet should be light and easily digestible. By careful attention and avoidance of exposure, together with the line of treatment mapped out, the vast majority of cases will recover. Of course, there are occasional cases which present symptoms which require other remedial agents, but these, of necessity, must be left to the discretion of the medical attendant."

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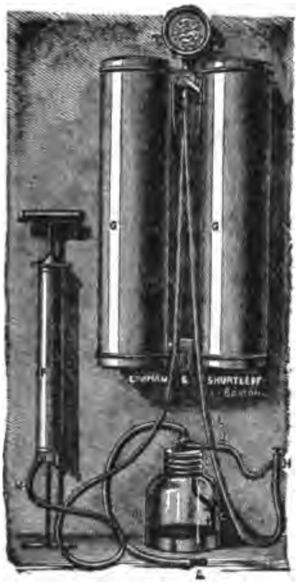

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